Third Edition

Guidance Document for the Sexual Violence Prevention and Education Cooperative Agreement CE07-701 (Rape Prevention and Education)

Overview

Purpose of Guidance Document

This document provides information on several key public health concepts and updated guidance on planning expectations outlined in the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control's (NCIPC, Sexual Violence Prevention and Education Cooperative Agreement CE07-701 for Part A grantees.

Contents

This publication contains information on the following topics:

Department of Health and Human Services
Public Service
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention

Guidance Document

Purpose of the Sexual Violence Prevention Cooperative Agreement

Cooperative Agreement CE07-701 builds and enhances grantees' capacity to effectively prevent sexual violence from initially occurring by preventing first time perpetration and victimization through:

- using a public health approach;
- supporting comprehensive primary prevention program planning at multiple social ecological levels;
- building individual, organizational and community capacity for prevention;
- applying the principles of effective prevention strategies; and,
- evaluating sexual violence primary prevention strategies and programs.

Utilization of Guidance Document

This document will guide the implementation efforts outlined in the Cooperative Agreement CE07-701 for Part A grantees regarding:

- enhancing legislatively approved activities;
- implementing and evaluating enhanced legislatively approved activities and strategies;
- conducting policy and norms change initiative;
- conducting community mobilization and coalition building efforts;
- planning and developing a comprehensive primary prevention plan;
- utilizing RPE Theory and Activities models in planning;
- developing primary prevention strategies (includes programs, policies, etc.);
- utilizing the ecological model in developing primary prevention strategies; and,
- expectations and clarification for program measures of effectiveness.

Prevention Concepts and Principles

The prevention concepts and principles discussed in this section are:

- Risk and Protective Factors
- Social Ecological Model (SEM)
- Universal and Selected Populations
- Before and After Prevention Concept
- Integration of Before and After Prevention Concept and the Social Ecological Model
- Principles of Effective Prevention Programs (Educational Sessions)
- Integration of the Comprehensive Prevention Principle and the Social Ecological Model

Risk and Protective Factors

Findings from research studies reveal some factors that may put people at risk for sexual violence perpetration and victimization or protect them from perpetrating or being victimized.

Risk factors are an attribute, situation, condition or environmental context that **increases the likelihood** of the occurrence of a health problem or behavior such as sexual violence.

Protective factors are an attribute, situation, condition, or environmental context that works to **decrease the likelihood** of the occurrence of a health problem or behavior such as sexual violence.

Being familiar with risk and protective factors will aid grantees in the development and/or enhancement of their sexual violence prevention programs. This information should be used to plan programs and to focus on strategies and/or programs that address the risk and protective factors for perpetration and/or victimization (Sexual Violence Prevention: Beginning the Dialogue, Centers for Disease Control and Prevention, 2004).

Please Note: Risk and protective factors are characteristics of either the person or their environment that are more easily modified, such as an individual's attitudes, relationship skills, social norms, and cultural traditions.

Risk groups are identified by demographic variables that are not easily changed, such as sex, race, age, income and education (Cox, 2004).

Table 1 presents various factors that have been found to increase a male's risk of committing rape (Krug et. al, 2002).

Limited research is available on protective factors for sexual violence, the literature suggests for youth some examples of protective factors are connectedness with school, friends and adults in the community and emotional health (Centers for Disease Control and Prevention, Sexual Violence: Fact Sheet, 2007).

However, there are a number of risk and protective factors that are common to all types of violence. **Table 2** presents the various shared risk and protective factors that occur at multiple social ecology levels for all types of violence (Krug et. al, 2002).

For additional information on risk and protective factors, please refer to:

- GTO IPV/SV Step 1
- WHO World Report on Violence and Health located at the below web address http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

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Table 1: Factors increasing men's risk of committing rape

Individual Factors	Relationship Factors	Community Factors	Societal Factors
o Alcohol and drug use o Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence o Impulsive and antisocial tendencies o Preference for impersonal sex o Hostility towards women o History of sexual abuse as a child o Witnessed family violence as a child	o Associate with sexually aggressive and delinquent peers o Family environment characterized by physical violence and few resources o Strongly patriarchal relationship or family environment o Emotionally unsupportive family environment o Family honor considered more important than the health and safety of the victim	o Poverty, mediated through forms of crisis of male identify o Lack of employment opportunities o Lack of institutional support from police and judicial system o General tolerance of sexual assault within the community o Weak community sanctions against perpetrators of sexual violence	o Social norms supportive of sexual violence o Social norms supportive of male superiority and sexual entitlement o Weak laws and polices related to sexual violence o Weak laws and policies related to gender equality o High levels of crime and other forms of violence

Table 2: Shared risk and protective factors for violence

	Individual Level	Relationship/Family Levels	Community and Societal Levels
Risk Factors	o School failure o Aggressiveness o Substance use/abuse o Depression/ hopelessness o Impulsivity o Poor peer relationships	o Dysfunction o Witnessing violence at home o Parental substance use/abuse o Parental depression	o Witnessing violence (media, policies) o Community attitudes related to violence, suicide and gender roles/sexuality
Protective Factors	o Problem solving skills o Sense of self-efficacy o Good peer relationships	o Parental supervision o Caring/respectful relationships o Social support	o Availability of services o Support/belonging

Use of Data to Identify State Specific Risk and Protective Factors

GTO IPV/SV Step 1 provides information on various existing sexual violence and intimate partner violence data sources. Some of those data sources (e.g. published data from research or national surveys, data locally generated through surveys, focus groups or other existing data sources) could be used to help identify state and/or community specific risk and protective factors and risk groups for sexual violence.

For some grantees, locally generated data may be the best available evidence to identify state and local risk factors. Examples of existing data sources may be call logs, chart reviews, hospital emergency department data.

Local generated data could be collected through special collection activities e.g. surveys, focus groups, BRFSS (Behavior Risk Factor Surveillance System), and YRBS (Youth Risk Behavior Survey)[1]. Focus groups with adolescents may be very informative for determining local dating attitudes, norms, and youth culture.

Additionally, focus groups are an ideal way to "test" draft materials (media campaigns, curriculums, etc.) with representatives from the group(s) that may be the focus of such materials to ensure audience receptivity.

What does not count as locally generated data? The opinions of researchers, advocates, health department personnel, school administrators etc. when used in isolation.

Ideally data should come from multiple sources so that such data can be compared and contrasted. For example, national surveys can be compared and contrasted with local surveys or focus group data to understand how a local community's attitudes regarding sexual violence are similar or different from the attitudes across the country (Cox, 2004).

Please Note: When using local data, issues and concerns related to confidentiality may arise; to ensure confidentiality, use aggregate data without personal identifiers.

Social Ecological Model (SEM)

To prevent sexual violence, we have to understand what circumstances and factors influence its occurrence. There are many models that illustrate the risk and protective factors of sexual violence.

Each model contributes to a better understanding of sexual violence and helps practitioners to build programs that sustain protective factors and reduce risk factors. The Social Ecological Model (**Figure 1**), one such model allows the incorporation of risk and protective factors from multiple domains.

Using the SEM provides a framework for understanding the complex interplay of individual, relationship, social, political, cultural, and

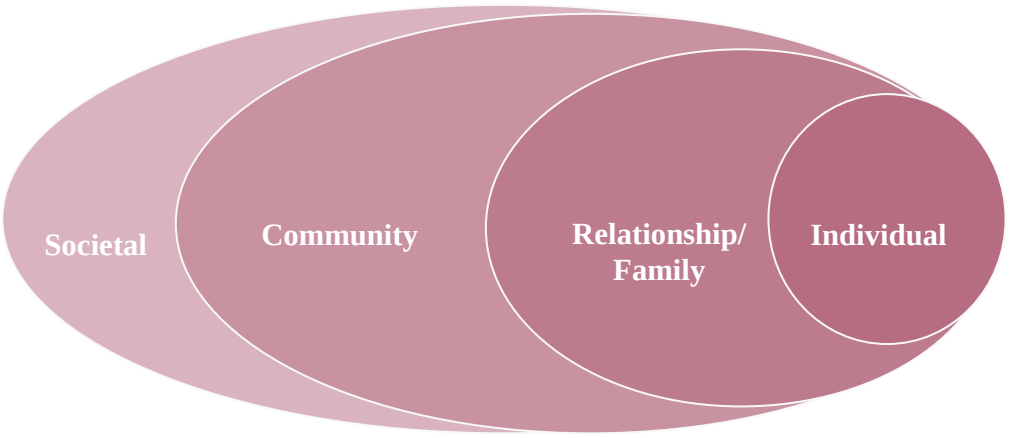
[1] Applicants may not use more than 2% of the RPE award received each fiscal year for surveillance or prevalence studies

environmental factors that influence sexual violence and also provides key points for prevention.

The social ecological model supports a comprehensive public health approach that not only addresses individual risk and protective factors, but also the norms, beliefs, and social and economic systems that create the conditions for the occurrence of sexual violence.

Figure 1 illustrates the levels of the ecological model

Figure 1: Social Ecological Model



Definitions of the Social Ecological Model Levels

Societal-level

Societal-level influences are larger, macro-level factors that influence sexual violence such as gender inequality, religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups of people. For example, rape is more common in cultures that promote male sexual entitlement and support an ideology of male superiority.

Strategies[2]/programs for societal-level typically involve collaborations by multiple partners to change laws and policies related to sexual violence or

[2] Strategy(ies) is defined as an approach to reduce violent behavior, such as social skills training, mentoring, social marketing, or policy changes. Definition adapted by the CDC GTO IPV/SV Development Team for the development of GTO IPV/SV.

gender inequality. (Sexual Violence Prevention: Beginning the Dialogue, Centers for Disease Control and Prevention, 2004). Strategies should focus on broad cultural, social or cultural norms, and economic factors related to violence.

Community-level

Community-level influences are factors that increase risk based on community and social environments and include an individual's experiences and relationships with schools, workplaces, and neighborhoods. For example, lack of sexual harassment policies in the workplace can send a message that sexual harassment is tolerated, and that there may be few or no consequences for those who harass others.

Strategies/programs[3] for community-level are typically designed to impact the climate, systems, and policies in a given setting that promote the violent behavior. Policy changes, social change strategies and opinion leader strategies are common approaches to modify the characteristics of settings such as schools, workplaces, and neighborhoods.

Interpersonal Relationship/ Family-level

Interpersonal relationship/family-level influences are factors that increase risk as a result of relationships with peers, intimate partners, and family members. A person's closest social circle—peers, partners, and family members—can shape the individual's behavior and range of experience.

Strategies/programs to address for interpersonal relationship-level could include parenting training.

Individual-level

Individual-level influences are biological and can include personal history factors that increase the likelihood that an individual will become a victim or perpetrator of violence. For example, factors such as alcohol and/or drug use; attitudes and beliefs that support sexual violence; impulsive and other antisocial tendencies; preference for impersonal sex; hostility towards women; and childhood history of sexual abuse or witnessing family violence may influence an individual's behavior choices that lead to perpetration of sexual violence.

Strategies/programs focus on changing an individual's knowledge, attitudes, and behavior through direct contact with that individual. Individual-level influences are often designed to target social and cognitive skills and behavior and include approaches such as educational training sessions that

[3] Program is defined as the combination of several complementary strategies designed to deliver reinforcing messages to one or more populations in a variety of settings. Definition adapted by the CDC GTO IPV/SV Development Team for the development of GTO IPV/SV.

are knowledge-focused, knowledge/attitude focused, and social/life skills focused.

Universal and Selected Populations for Sexual Violence Prevention

The primary prevention of sexual violence from a public health perspective focuses on preventing first-time perpetration and first time victimization. To facilitate this approach you will need to identify and address the needs of populations that have not experienced or perpetrated sexual violence.

For planning purposes, populations that have not experienced or perpetrated sexual violence are classified into two separate categories based differences in modifiable risk. These two categories are universal populations and selected populations.

What are Universal Populations?

A universal population is a population within your state or community that is defined **without** regard to individual risk for sexual violence perpetration or victimization (Krug et. al., 2002). A state or community may have multiple universal populations.

A universal population may include individuals with elevated risk for experiencing sexual violence, individuals at lower risk for experiencing sexual violence, as well as individuals who have already experienced or perpetrated sexual violence. **A key point to remember when identifying universal populations is that the population is defined without regard to risk.**

Examples of Universal Populations

Here are some examples of universal populations:

- the population of an entire state,
- the population of an entire county,
- the population of an entire school, or
- the population of males ages 14-18 in a state

Benefit to Identifying Universal Populations

Defining universal populations is a critical aspect of primary prevention from the public health perspective Through the identification of a universal population, strategies can be developed that reduce the overall risk for sexual violence for the entire universal population, including risk groups, often leading to overall reductions of sexual violence perpetration and

victimization.

What are Selected Populations?

A selected population is a group or population within a universal population that is defined by increased risk for experiencing or perpetrating sexual violence based on one or more modifiable **risk factors** (Krug et. al., 2002). A selected population is always part of some universal population.

Example of Selected Populations

Here is an example of a selected population:

Males ages 14-18 who have the following modifiable risk factors:

- have hostile attitudes toward women;
- drink to excess more than 2 times a week; and,
- experience poor family functioning

This example identifies a selected population by connecting a risk group (males ages 14-18) with specific modifiable risk factors (i.e., attitudes, behaviors, and relationship factors) that increase their risk to perpetrate sexual violence.

Benefits to Identifying Selected Populations

Identifying selected populations is also a critical aspect of primary prevention from the public health perspective. By knowing who is most affected by a problem states and communities can utilize resources more effectively and efficiently in their efforts to prevent sexual violence.

Individuals who are at higher risk of perpetrating or experiencing sexual violence can have strategies developed that better address their unique needs.

Before and After Prevention Concept

Public health programs are often grouped into three prevention categories based on event occurrence. Sexual violence approaches can be divided into the following three categories:

- **primary prevention**: approaches that take place **before** sexual violence has occurred to prevent initial perpetration or victimization;

- **secondary prevention**: immediate responses **after** sexual violence has occurred to deal with the short-term consequences of violence; and,

- **tertiary prevention**: long-term responses **after** sexual violence has occurred to deal with the lasting consequences of violence and sex offender treatment program.

(Sexual Violence Prevention: Beginning the Dialogue, Centers for Disease Control and Prevention, 2004).

Please Note: CDC expects RPE grantees to implement sexual violence prevention programs that aim to prevent sexual violence from initially occurring.

Integration of Before and After Prevention Concept and the Social Ecological Model

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In the development and/or enhancement of RPE strategies/programs it is important that the strategies are primary prevention focused. **Table 3** provides a comparison of primary prevention strategies (preventing violence **before** it occurs), and secondary and tertiary prevention strategies that take place **after** violence has occurred) across all levels of the ecological model (Sexual Violence Prevention: Beginning the Dialogue, Centers for Disease Control and Prevention, 2004).

Table 3: The BEFORE and AFTER Matrix

	Individual	Relationship	Community	Societal
Before (Primary Prevention)	Implement and evaluate discussion groups among men that explore prevalent notions of masculinity and their relationship with sexual violence; healthy and respectful relationship; and men's role in prevention sexual violence.	Implement and evaluate a discussion group based intervention with male peer groups (e.g. fraternities, athletic teams) to change group norms that support and condone sexual harassment and violence. Men will learn to hold their peers accountable for attitudes and behaviors that support sexual violence.	Engage youth as agents of change to affect their school's climate of tolerance for sexualized bullying by leading classroom-based conversations with school-wide special events.	Assist in educating legislators about the importance of economic and educational policies that promote the economic status of women and reduce inequalities in employment.
After (Secondary and Tertiary Prevention)	Provide offender treatment services for perpetrators. Provide crisis intervention services for sexual assault survivors.	Provide services to family members of sexual assault survivors to assist them in resolving the impact of the assault and to help them be sensitive and supportive of the survivor.	Develop police protocols for responding to and investigating reports of sexual assaults. Hold "Take Back the Night" rallies to raise community awareness of the scope, nature, and impact of sexual violence.	Assist in educating legislators about the importance of mandatory legislation that ensures all survivors of sexual assault the provision of a forensic medical exam at no charge.

Principles of Effective Education Prevention Programs (Educational Training)

According to the **2003 Nation et. al article (Appendix A)**; there are nine principles that can help prevention practitioners select, modify, or create more effective education programs. These nine principles are:

1. Comprehensive
2. Varied Teaching Methods (Active, Skill-based Teaching Activities)
3. Sufficient Dosage
4. Theory Driven
5. Positive Relationships

6. Appropriately Timed
7. Socio-culturally Relevant
8. Outcome Evaluation
9. Well-trained Staff

Definitions for the prevention principles in the section below. Refer to **Nation et. al article (Appendix A)** for detailed information regarding the prevention principles.

Please Note: Refer to the information below regarding incorporating principles into prevention programming:

- How to Enhance Legislatively Approved Prevention Activities section;
- **Draft Rape Prevention and Education (RPE) Practice Guidelines (Appendix B)**; and,
- **Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)**

Principles of Effective Programs Definitions

Comprehensive

Multicomponent approaches that address critical domains (e.g. family, peers, community) that influence the development and perpetuation of the behaviors to be prevented.

Varied Teaching Methods

Programs which involve diverse teaching methods that focuses on increasing the awareness and understanding of the problem behaviors and on acquiring or enhancing skills.

Please Note: If using GTO IPV/SV, the CDC GTO Development Team refers to this principle as Active, Skill-based Teaching Activities.

Sufficient Dosage

Programs that provide enough intervention to produce the desired effects and provide follow-up as necessary to maintain effects.

Theory Driven	Programs that have theoretical justifications that are based on accurate information, and are supported by empirical research.
Positive Relationships	Programs that provide exposure to adults and peers in a way which promotes strong relationships and supports positive outcomes.
Appropriately Timed	Programs that are initiated early enough to have an impact on the development of the problem behavior and are sensitive to the developmental needs of participants.
Socio-culturally Relevant	Programs that are tailored to the community and cultural norms of the participants and make efforts to include the target group in program planning and implementation.
Outcome Evaluation	Programs that have clear goals and objectives and make an effort to systemically document their results relative to the goals.
Well-trained Staff	Program staff that support the program and are provided with training regarding the implementation of the intervention.

Integration of the Comprehensive Prevention Principle and the Social Ecological Model

Addressing the prevention principle of comprehensive involves the creation of a comprehensive prevention program, which is the combination of complementary and synergistic prevention strategies across the levels of the social ecology that address the needs of a universal or selected population.

Strategies are complementary and synergistic when they focus on the same group and when a strategy implemented at one level of the social ecology reinforces a strategy at another level of the social ecology. The strategies at different levels of the social ecology address the same risk or protective factors.

The social ecological model supports the comprehensive prevention principle by addressing an individual's risk factors as well as norms, beliefs, and social and economic systems that create the conditions for the occurrence of sexual violence.

For instance, a school may implement a teen dating violence curriculum (an individual level strategy) and complement it with a parenting strategy (a relationship level strategy). Within the parenting strategy, parents would be encouraged to reinforce messages about healthy dating when interacting with their children. The synergy between two strategies occurs when the two strategies together have more of a preventative effect than either strategy alone.

No single factor at any level of the social ecology can explain why certain individuals perpetrate sexual violence (Dahlberg & Krug, 2002) or why certain groups are more at risk for sexual violence victimization, thus comprehensive prevention programs to prevent sexual violence are needed.

Comprehensive prevention programs attempt to address the complex interplay of risk and protective factors with a complementary mix of strategies across the various levels of the social ecology. Strategies that focus only on one level of the social ecology are unable to address this complex interplay of risk and protective factors.

Thus, to increase the effectiveness of RPE programs/strategies, the strategies/programs should address several levels of the social ecological model.

In developing a comprehensive primary prevention program, grantees and their planning committees should strive to develop:

- a continuum of program/strategies throughout the various levels of the social ecological model (Figure 1); and,

- appropriate programs/strategies conducted over several lifestages; as these are more likely to promote and sustain sexual violence prevention across a lifetime, rather than a single intervention or a single policy change.

Additional information regarding lifestages can be found in the CDC Goals and Lifestages section of this guidance document.

Example

Figure 2 illustrates an example of a comprehensive primary prevention strategy in a school setting using an ecological approach.

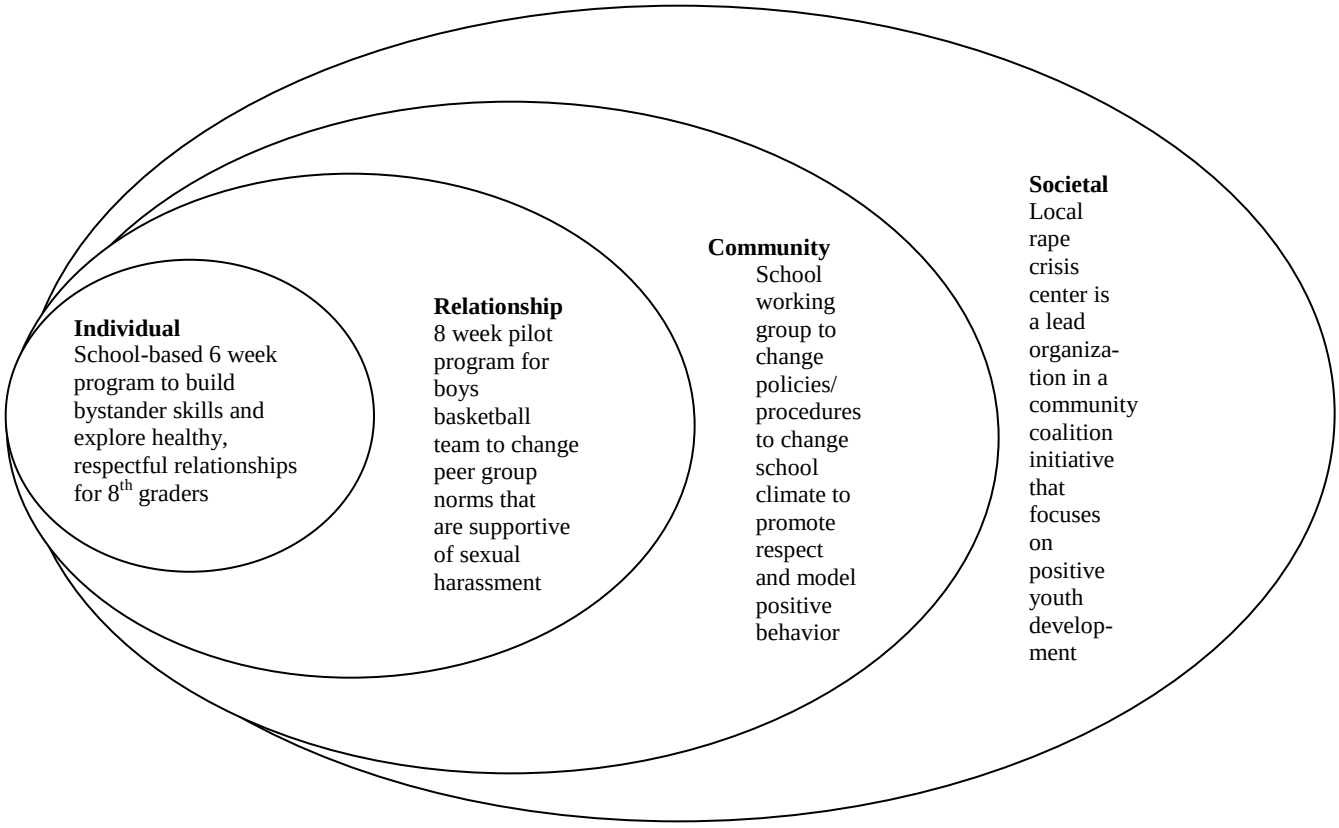
A school-based curriculum focused on shifting gender roles and defining healthy relationships for a group of 8th graders is working to influence the **student** (**Individual level change**) as the curriculum works to change individual knowledge, attitudes and behaviors. Although it is set in a school, the change does not take place school wide as the culture of the school has not been addressed.

The change is being pursued one person at a time through the curriculum. To make this effort comprehensive, additional activities are necessary. Thus your program plan might include a pilot program focused on young boys working to influence peer group norms **(Relationship level change)** that are supportive of sexual harassment and sexual violence.

For additional comprehensiveness, a school working group might be formed to change the policies and procedures of the school thus changing its climate and environment concerning the acceptance of violence as a norm and honoring and modeling respectful and positive interactions. This is a **Community level change** that will, hopefully, support and reinforce changes in individual behavior.

Ideally, individual, relationship and community change would be pursued within this school and supported by **Societal level changes** being implemented by a local rape crisis center is implementing a community wide sexual violence prevention initiative that includes a focus on positive youth development.

Figure 2: Comprehensive School- based Program and Ecological Model Example



Legislatively Approved Prevention Activities and Complimentary Activities

Legislatively Approved Activities

For the purposes of this cooperative agreement, grantees should reflect a commitment to enhance the effectiveness of the federally legislatively approved activities to prevent first time perpetration and victimization.

The legislatively approved prevention activities are as follows:

- Educational seminars;
- Operation of hotlines;
- Training programs for professionals;
- Preparation of information material;
- Training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities;
- Education to increase the awareness about drugs used to facilitate rapes or sexual assault; and
- Other efforts to increase awareness of the facts about or to help prevent, sexual assault, including efforts to increase awareness in underserved communities and awareness among individuals with disabilities as defined in Section3 of the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12102).

Complimentary Strategies to Legislatively Approved Activities

In addition to implementing and enhancing the legislatively approved activities, grantees should also address the complimentary strategies of:

- coalition building;
- community mobilization; and
- policy and norms change.

Please Note: Additional information about the complimentary strategies is located below and in the draft documents **RPE Practice Guidelines**

(Appendix B) and **Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)**.

Coalition Building

Coalition building is the process by which community members and organizations come together to achieve a common goal, in this case preventing sexual violence. Ideally, the process of coalition building includes a broad spectrum of the community working together to jointly develop a vision, mission and goals and to take action. Coalition building encourages collaboration, defined as exchanging information, modifying activities and sharing risks, resources, responsibilities and rewards. Coalition building can occur at the state and/or community level.

Coalitions often are the cornerstones of creating successful change within a community. A well-organized, broad-based coalition can be more successful than a single agency in creating policy change, increasing public knowledge, and developing innovative solutions to complex problems.

Community Mobilization

Community mobilization is engendering change in communities by facilitating community ownership and action to prevent sexual violence. Community mobilization facilitates shifting ownership for the SOLUTION to the community to impact underlying/root causes of sexual violence.

While community mobilization is about facilitating community ownership and action to prevent sexual violence coalition building is about individuals and agencies working together in collaboration to prevent sexual violence. Incorporating community mobilizing initiatives into prevention efforts brings individuals back to the roots of sexual violence being a social change movement. Building the capacity of communities to prevent sexual violence and increases the potential for lasting, substantive change at the individual AND community level.

Policy and Norms change

Sometimes the best way to address a problem or issue is develop and implement a new (or better policy) and/or norms change. For social and cultural norm changes implementing such strategies as state-wide social norm campaigns or social marketing campaigns can promote the behaviors you want other to adopt, e.g. behaviors associated with decreased sexual violence.

These strategies can be implemented in a variety of settings such as school, college campuses, workplaces, neighborhoods, and the broader community. In addition, both public and organizational polices can lead to norms change and may have a board impact.

Enhancement of Legislatively Approved Prevention Activities

Why Enhance Legislatively Approved Prevention Activities?

Rape Prevention and Education (RPE) grantees are expected to plan while continuing to implement and increase efforts to move along the prevention continuum from basic awareness activities to those strategies that change beliefs, attitudes, and behaviors and policies that support or allow sexual violence to occur.

While important, awareness activities, in and of themselves, **will not change beliefs, attitudes, behaviors and policies regarding sexual violence.** Therefore, programs addressing sexual violence prevention should have as its core the goal of change.

Implemented sexual violence prevention activities for legislatively approved activities should align with NCIPC's working definition of sexual violence prevention for the RPE program which is:

- population-based and/or environmental and system-level strategies, policies, and actions that prevent sexual violence from initially occurring.

Such prevention efforts work to modify and/or reduce the events, conditions, situations, or exposure to influences (risk factors) that are associated with the initiation of sexual violence and related injuries, disabilities, and deaths.

Sexual violence prevention efforts should address perpetration, victimization, bystander attitudes and behaviors, and seek to identify and enhance protective factors to impede the initiation of sexual violence (Sexual Violence Prevention: Beginning the Dialogue, Centers for Disease Control and Prevention, 2004).

The range of sexual violence prevention strategies should be broad and multifaceted, and requires the skills and approaches from many disciplines and areas of expertise.

Through the RPE program, grantees will promote efforts to modify or eliminate the individual, relationship, community, and societal influences that are associated with the perpetration, victimization, and bystander attitudes and behaviors that allow sexual violence to occur.

How to Enhance Legislatively Approved Activities

Much of current RPE programming is focused on reducing risk of victimization or raising awareness of sexual violence. To enhance the effectiveness of current federally legislatively approved activities to prevent first time perpetration and victimization, a general assessment of the RPE program and prevention activities should occur.

The below assessment questions will aid grantees to identify areas to enhance and focus programming efforts to prevent first time perpetration and victimization.

Questions to guide overall program enhancement efforts

The below questions will guide the **overall** program assessment and where the RPE program should focus on.

- Program assessment – What have your past efforts achieved? How do these achievements align with your initial goals or objectives? What program information or data is available to help you make decisions to continue or discontinue an effort?

- Surveillance data – What does your sexual violence surveillance or other sources of data indicate about sexual violence trends, priority populations and where to focus efforts?

- Capacity –What is your current capacity (personnel, funding, partners, contractors) to implement program strategies?

- Outcome of Interest – What do you hope to achieve by implementing your strategies?

Questions to guide surveillance data enhancement efforts

Up to 2% of RPE budgets may be devoted to surveillance activities Surveillance information is a critical component for making decisions about program direction and priorities and will be important for assessing progress in achieving program goals.

Grantees should incorporate population-based surveillance data sources available in the state (YRBS, BRFSS or similar surveys)

1. What population based sexual violence surveillance data are available in your state?

2. What surveillance data are available to guide sexual violence perpetration prevention activities?

3. Is data easily accessible and timely?

4. How will data be used and shared with others?

Helpful Reminder

The information gathered above could be used to inform the goal and outcome statement (objective) development process if using the Getting To Outcomes for Primary Prevention of Intimate Partner Violence and Sexual Violence Prevention (GTO IPV/SV) planning process.

Programmatic Activities and/or Strategies Guidelines to Enhance Legislatively Approved Activities

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While assessing current programmatic activities, here are some guidelines to remember what would help with the enhancement and/or transition to first time perpetration and victimization programmatic activity/strategies.

The activity/strategy should focus and/or include efforts that::

- Focus on primary prevention. Primary prevention is any action, strategy or policy that prevents sexual violence from initially occurring.

- Integrate the Social Ecological Framework. The Social Ecological Model supports comprehensive approaches and promotes working at various levels, including individual, relationship, community and society.

- Include partnerships and collaboration efforts which can enhance program capacity to achieve intended outcomes.

- Integrate cultural relevance and specificity of prevention strategies. Activities/strategies should be appropriate for the populations for whom the strategy is intended and take into account that communities' culture.

- Incorporate surveillance efforts and tools. YRBS and BRFSS or similar data sources enhance the ability to assess and track changes in sexual violence behaviors over time.

- Assess outcome and process Evaluation indicators and measures to document changes in individual and community attitudes, behaviors

and norms related to sexual violence. Process evaluation will help to assess actions taken to realize goals.

Below are specific assessment questions related to each legislatively approved prevention activity help grantees identify the enhancements that need to be incorporated into programmatic and prevention efforts.

Assessment Questions for Legislatively Approved Prevention Activities

Educational Seminars Enhancement Assessment Questions?

1. Is content prevention focused?
   - o Do the education sessions incorporate the relevant prevention principles outlined in the **Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)**?
2. What is the rationale for groups/individuals selected for educational sessions?
3. Are proposed educational sessions intended to go beyond awareness raising to include attitude, behavior or norms change?
4. Are proposed education sessions geared toward youth, men and boys, and adults who have ability to influence or act as change agents in prevention efforts? Will efforts address bystander attitudes?
5. Are the educational seminars supported by other activities such as organizational policy/practice/norms change?
6. What is the expected result?
7. How will success be measured?
   - o Possible outcome measures for educational seminars: changes in individual or community beliefs, attitudes, behaviors; changes in procedures, practices or policies; other?
   - o Possible process measures for educational seminars: number of sessions; types of audiences (youth/parents/influential others?); number of individuals reached; others?

Please Note: General sexual violence educational sessions such as prevalence and dynamics of sexual violence, laws and statutes, as needed and intervention-based sexual violence educational sessions such as, how to help a victim, recognizing warning signs, etc. are not sufficient to change behavior and prevent sexual violence from occurring.

Consequently, educational sessions can include general sexual violence and intervention-based topics or information as long as they are **part of a broader** primary prevention strategy (e.g. a multi-session program that includes healthy relationships; sexual harassment; bystander skill building; gender roles and expectations; consent and coercion; sexual assault laws; community resources; what to do if you have been raped).

Operation of Hotlines Enhancement Assessment Questions?

1. Are proposed hotline activities within the range of approved activities, examples:
   - o training for volunteers
   - o supporting phone lines and 1-800 numbers
   - o developing and printing training manuals
   - o establishing language line and/or TTY lines
   - o advertising and marketing
   - o purchasing beepers and cell phones
   - o answering services
2. Are there opportunities to include prevention efforts?

How will Success be Measured?

Possible outcome measures for operation of hotlines: number of appropriate referrals; changes in hotline policies, practices, procedures related to sexual violence prevention; other?

Possible process measures for operation of hotlines: number of calls received; number of callers assisted; other?

Training Programs for Professionals Enhancement Assessment Questions?

1. Are training programs prevention focused?
2. What is the rationale for training these groups?
3. Are professionals to be trained in a position to impact prevention efforts, for example, do they have access to:
   - o Youth
   - o Men and boys
4. Are adult learning practices incorporated? See the **Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)** for information on Training Professionals for Sexual Violence Prevention.

Please Note: Professional training or systems change work that has a goal to educate and/or improve the response to victims (e.g. SART training, training for judges on statutes, training for health professionals and law enforcement on appropriate response, investigation and/or prosecution) is **not an appropriate** use of RPE funds.

How will Success be Measured?

Possible outcome measures for training programs for professionals: changes in individual beliefs, attitudes, behaviors; changes in procedures, practices or policies; other?

Possible process measures for training programs for professionals: number of training sessions; number and types of professionals trained; other?

Preparation of Informational Materials Enhancement Assessment Questions?

1. Are materials prevention focused?
2. Are materials linked to or in support of other prevention program efforts?
3. Are there plans to test materials in the development phase?
4. Are there plans to ensure cultural relevance?
5. Is the use of CDCYNERGY incorporated in the planning, if a media campaign is proposed?

How will Success be Measured?

Possible outcome measures for preparation of informational materials: changes in individual beliefs, attitudes, behaviors; changes in procedures, practices or policies; other?

Possible process measures for preparation of information materials: number of informational units developed, translated etc.; number of informational materials distributed; other?

Training Programs for Students and Campus Personnel Enhancement Assessment Questions?

1. Are training programs prevention focused? See the **Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)** on incorporating the nine prevention principles and Training Professionals for Sexual Violence Prevention.
2. Are there opportunities to engage a broad spectrum of campus personnel and students?
3. Are there opportunities to engage men as change agents?
4. Are there opportunities to impact college culture/climate?
5. Are there opportunities to address organizational practices or policy?

How will Success be Measured?

Possible outcome measures for training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities: changes in individual beliefs, attitudes, behaviors; changes in campus procedures, practices or policies; other?

Possible process measures for training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities: number and type of trainings for students; number and type of trainings for campus personnel; other?

Increase Awareness of Drug Facilitated Rapes or Sexual Assaults Enhancement Assessment Questions?

1. Are there opportunities to include prevention efforts?
2. What data is available to describe the problem of drug facilitated rape in your state or communities within your state?
3. Are there opportunities for collaboration with substance abuse prevention specialist at your state or local level?

How will Success be Measured?

Possible outcome measures for education to increase the awareness about drugs used to facilitate rapes or sexual assault: changes in individual beliefs, attitudes, behaviors; changes in campus procedures, practices or policies; other?

Possible process measures for education to increase the awareness about drugs used to facilitate rapes or sexual assault: number and types of efforts to increase awareness of drug facilitated rapes; number of individuals reached; other?

Other Efforts to Increase Sexual Assault Awareness Enhancement Assessment Questions?

1. Are proposed efforts prevention focused? See the **Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence (Appendix C)** for information on incorporating the nine prevention principles and the **Draft Practice Guidelines for Coalition Building for Sexual Violence Prevention and Mobilizing Communities for Sexual Violence Prevention (Appendix B)** for other efforts. In addition, refer to the culturally relevant strategies and community mobilization section in the guidance document.
2. What is known about underserved communities?
3. What data can be used to determine priority populations?
4. Are efforts culturally relevant? How do you know?
5. Are there partners who are knowledge and willing to assist in addressing the needs of access to priority populations?

How will Success be Measured?

Possible outcome measure for other efforts to increase awareness of the facts about or to help prevent sexual assaults: changes in individual beliefs, attitudes, behaviors; changes in sexual violence prevention procedures, practices or policies impacting underserved communities; other?

Possible process measures for other efforts to increase awareness of the facts about or to help prevent sexual assaults: number and types of efforts; number of individuals reached; other?

Helpful Reminder

The data gathered from the above legislatively approved prevention activities assessment questions could be used to inform the evidence based prevention strategies identification and development process if using GTO IPV/SV as a planning process.

RPE Theory and Activities Models and Program Planning

History

In February 2004, CDC, NCIPC, Division of Violence Prevention (DVP) embarked on a strategic planning process involving key RPE stakeholders to develop a mission, vision, and strategies for the National RPE Program.

New Models

The national strategic planning process continued in 2006 with CDC collaborating with contractors and RPE stakeholders to develop two logic models:

1. **Creating Safer Communities: RPE Model of Community Change Theory Mode**l; and,

2. **Creating Safer Communities: RPE Model of Community Change Activities Models (Appendix D)**

The RPE Theory and Activities models build upon the 2004 road map. The theory and activities models provide the foundation for the next steps in RPE strategic planning and the development of indicators and process, short-term and intermediate outcome measures.

Additional information regarding the models refer to **Creating Safer Communities: RPE Model for Community Change Theory Model, Activities Models, Frequently Asked Questions, and Literature Review** located in **Appendix D**.

Theory Model and the Planning Process

RPE grantees and their planning teams should use the RPE Theory Model to set the context for their planning process. The Theory Model is a tool for exploring the "big picture" and having a constructive dialog about where you are now and where you want to go with your RPE Program, starting with your needs and resources assessments (GTO IPV/SV Step 1) and continuing through sustainability (GTO IPV/SV Step 10).

To guide the planning process, the Theory Model should be referred to at each step. For example, the vision statement development process should be informed by the RPE Theory of Change model's emphasis on norms change, prevention of perpetration, and promotion of safety, equality and respect.

Tools and/or Resources

The **Creating Safer Communities: RPE Model for Community Change Theory Model Literature Review** (**Appendix D**) is an additional tool to support planning work. The literature review summarizes the underlying

theories and empirical research that form the scientific basis for the RPE theory model.

The literature review will be:

1. helpful in providing a more in-depth understanding of the underlying theories that are the basis of the model; and,

2. helpful in identifying and selecting potential prevention strategies.

The prevention strategies that are selected should be based on theories that have been validated by research to lead to behavior or social change. Strategies supported by a well-validated behavior or social change theory have a greater likelihood of achieving their goals. This literature review outlines a major community-change theory (Diffusion of Innovation) as well as three theories of individual behavior change that can form the basis of the prevention strategies.

These are not the only theories out there and SVPP committees can certainly utilize others however the theories outlined in the literature review do have some empirical support in other related social and health problems (e.g. HIV/AIDS prevention). Because the field of sexual violence research is relatively young there is limited research on effective models for sexual violence prevention in specific.

Please Note: The RPE Theory Model should be used in its entirety and **should not be modified** by grantees or their planning teams. The Theory Model was developed specifically for the RPE Program through a collaborative process and is based on the best available research to date. Therefore, RPE Programs should not create their own theory models.

Activities Models and the Planning Process

Grantees and planning teams should create their own Activities Models as part of their planning process using the RPE Activities Models as a starting point.

For grantees and planning teams using GTO IPV/SV to guide their planning process, resources/inputs will be identified in Step 1 (needs and resources assessment) and refined in Step 5 (capacity); strategies will be identified in Steps 3-5 (evidence based prevention strategies, contextual fit and capacity); and *outcomes and impacts will be identified in Steps 7-9 (outcome evaluation and continuous quality improvement).

In addition, the logic model developed using GTO IPV/SV will look different than the RPE activities models. **Appendix L** provides a recommended **GTO format – Universal and Selected** for logic model development.

Please Note: If creating a statewide plan that's broader than the RPE program, please create two logic models. The first logic model should be for the RPE program only. The second logic model should be for the broader statewide sexual violence efforts.

***Please Note:** Through the development of the **RPE Theory and Activities models** (**Appendix D**), meaningful short-term and intermediate outcome measures and indicators will be identified by CDC through the RPE Indicators Project and adopted by grantees. These measures and indicators will be available Winter 2008.

Tools and/or Resources

Logic models can be viewed at the below websites:

- http://www.cdc.gov/healthyyouth/evaluation/pdf/logic-model-basics.pdf,
- http://www.cdc.gov/eval/evalguide.pdf
- http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf
- http://communitiesconnect.wikispaces.com/space/showimage/OutcomesBased+Evaluations+Using+the+Logic+Model_2002.pdf

Comprehensive Primary Prevention Program Planning

CDC Expectations

Historically RPE programming was focused on reducing risk of victimization or raising awareness of sexual violence. The transition to a more dominant focus to preventing first time perpetration and victimization will bring better balance to overall prevention efforts.

To prevent sexual violence from initially occurring efforts are needed that stop first time perpetration rather than relying on efforts that seek only to prevent victimization.

Thus, in years one and two of the cooperative agreement, RPE grantees are expected to implement a planning process with a statewide Sexual Violence Prevention Planning Committee to create a comprehensive primary prevention program plan that would address the prevention of first time perpetration and victimization.

Please Note: CDC expects grantees to include goals and strategies to prevent both first time perpetration and victimization in their comprehensive plan; the goals and strategies should have the appropriate balance between perpetration and victimization prevention.

Planning Process Components

The comprehensive primary prevention program planning process should include:

- developing a Statewide Sexual Violence Prevention Planning Committee (SVPP committee);
- implementing various needs and resources assessments including data collection on demographic, economic, sexual violence prevalence and risk and protective factor data;
- implementing an assessment of state and local prevention strategies and capacity;
- implementing an evaluation assessment of evaluation activities and capacity;
- implementing an assessment of state training and technical assistance needs;
- implementing an assessment of state health department and sexual assault coalition capacity to offer training and technical assistance;

- o implementing a prevention system capacity assessment (optional); additional information about this can be found later in the section and in GTO IPV/SV Step 5.
- o developing goals and outcome statements (objectives) for universal and selected populations and prevention system (optional);
- o identifying new and/or enhancing evidence based prevention strategies/programs for universal and selected populations; and,
- o developing process measures to evaluate planning efforts.

Tools and/or Resource

The Rape Prevention and Education (RPE) Cooperative Agreement Revised Benchmarks for Success and Recommended Timelines dated **June 25, 2008*** and located in **Appendix F** provides additional information on planning components and benchmarks.

***Please Note:** Disregard the Revised Year 2 Benchmarks for Success and Recommended Timelines dated February 8, 2008. That version is no longer current; please use the document located in Appendix F.

Use of GTO IPV/SV in Planning Process

CDC recommends grantees use GTO IPV/SV to guide their planning process; however grantees can use other planning resources to facilitate their planning process. Please contact your Project Officer for a copy of GTO IPV/SV as well as for technical assistance using GTO IPV/SV.

Refer to Resources section of the Guidance Document for additional recommendations.

Information on Planning Components - GTO IPV/SV Step 1

Introduction

The planning process goal is to create a comprehensive primary prevention program plan that includes goals and strategies/programs to prevent both first time perpetration and victimization.

This section provides information on the various components of the planning process and is presented as they relate to the steps in GTO IPV/SV. Topics discussed in this section are:

- Sexual Violence Prevention Planning Committee (SVPP committee)
- Assessments

Please Note: Refer to the RPE Theory and Activities Models section on how to use the models in planning efforts.

Sexual Violence Prevention Planning Committee

An integral part of the comprehensive primary prevention program planning process will be the creation (or possible expansion) and maintenance of a Sexual Violence Prevention Planning Committee. The committee should be comprised of key state and community partners.

Committee members should provide input and guidance in the planning process. The Committee should be involved throughout the entire 5 year project period to provide guidance and technical assistance, and support the adoption, promotion and sustainability of the prevention plan.

Required Planning Committee Members

The Sexual Violence Prevention Planning (SVPP) Committee **must** be comprised of representatives from:

- the Health Department (RPE Director and other relevant department staff representatives e.g. prevention, maternal and child health, adolescent health, substance abuse prevention specialist, family planning, epidemiologist, evaluator);
- the State Sexual Assault Coalition Executive Director and/or selected coalition prevention staff;
- representatives from agencies or community based organizations

including rape crisis centers; and,

- agencies involved in preventing sexual violence who are currently not receiving RPE funds

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Recommended Planning Committee Members

Additional representatives CDC strongly recommends as members of the Sexual Violence Prevention Planning Committee are:

- community partners;
- youth-serving organizations;
- organizations working with men and boys e.g. Boy Scouts, athletic clubs;
- organizations serving marginalized communities;
- universities and colleges;
- community based organizations currently conducting and/or prepared to conduct primary prevention programs;
- faith-based organizations;
- Health Department leadership; and,
- others agencies/organizations as appropriate.

Tools and/or Resources

Refer to the March 2007 PowerPoint presentation and/or web seminar conduced by CDC and EMPOWER grantees on *Developing State Planning Teams* for additional guidance on developing state planning committees.

An archive copy of the *Developing State Planning Teams* PowerPoint presentation and web seminar is on the NSVRC website, www.nsvrc.org. Contact your Project Officer if you have questions on how to access the archived web conference.

Information Needed for Comprehensive Primary Prevention Plan

While planning, remember to document information that could be incorporated into the Comprehensive Primary Prevention Plan. CDC recommends the following information be placed into the plan:

1. List of SVPP committee members at time Plan was developed and their affiliations

2. Describe how SVPP committee members were recruited and how they were representative of:

    - o the state, including various community sectors e.g. based on ethnicity, gender, sexual orientation
    - o pertinent sectors and agencies e.g. public health, local rape crisis centers, education, faith, business, youth organizations, men's groups
    - o leaders from community organizations
    - o people with experience working in primary prevention and/or sexual violence
    - o organizations likely to be involved in providing resources and/or implementing the Plan

3. Describe the SVPP committee processes:

    - o how members participated and how active that participation was;
    - o the frequency of meetings/conference calls, use of list serves, use of subcommittees; and,
    - o processes used to make decisions and the development of the actual plan.

Refer to the Comprehensive Primary Prevention Plan Guidance (GTO IPV/SV Step 6) section for additional information regarding plan expectations and components.

Tools and/or Resource

Appendix E provides information on the importance of having representation from the above **list on the Sexual Violence Prevention Planning Committee** and provides suggestions on how to solicit their involvement on the SVPP committee.

The identified representatives should assist in enhancing and supporting the RPE Programs movement toward comprehensive primary prevention programming and be involved in the prioritization and implementation of the new and/or enhanced prevention strategies.

As part of CDC's technical assistance process, information and guidance regarding the available tools will be provided; for additional information on this, refer to Federal Involvement under Cooperative Agreements section.

Planning Assessments

Before Implementing Assessments

Before implementing any needs and resources assessments, the tasks below should be completed by SVPP committee :

- o develop a shared definition and understanding of sexual violence;
- o develop a shared prevention vision for your SVPP committee;
- o discuss the purpose of the Comprehensive Primary Prevention Plan and,
- o form a needs and resources assessment work group.

As a reminder, **The Rape Prevention and Education (RPE) Cooperative Agreement, Revised Benchmarks for Success and Recommended Timelines dated June 25, 2008** (**Appendix F**) provides information on planning benchmarks.

Why are Assessments Important?

Needs and resources assessments provide the foundation for the rest of the planning process. Without the information from a systematic needs and resources assessment, prevention plans are often based on the assumptions, beliefs, politics, and personal experiences of a few people who do not necessarily represent the community or state as a whole.

The benefits to having a comprehensive and inclusive needs and resources assessment process that is inclusive of SVPP committee members is that stakeholders:

- o gain better understanding of the state's needs and resources;
- o develop a common understanding of the state's needs and resources; and,
- o communicate needs and resources in a consistent and unified manner.

CDC expects the SVPP committee to provide guidance on the development and focus of the needs and resource assessment and help interpret findings.

State Assessment

A statewide needs and recourses assessment should provide a picture of the state as a whole as well as the differences among regions/counties and demographic groups within the state.

The more the SVPP committee understands about the changing conditions that characterize the state, the more prepared the SVPP committee will be to develop a prevention plan that fits and is able to adapt to the changing conditions and environment within the state.

The state assessment should include information about:

- o demographics e.g. number of individuals and family household, age distribution, sex distribution, racial/ethnic composition, number of people with disabilities, distribution of urban, rural, immigrant/refugee;
- o economics e.g. annual household income, major employers, unemployment rates;
- o individual and community level resources and assets, current prevention programming and capacity;
- o magnitude of sexual violence e.g. sexual violence data from multiple sources; sexual violence data for sub populations (age, gender, ethnicity, sexual orientation etc.); and,
- o risk and protective factors that contribute to sexual violence.

CDC Expectations for State Assessment

CDC expects grantees and their SVPP committees to collect the **minimal information** listed below in their state assessments. If grantees and their SVPP committees have additional resources and/or interest, they could provide the up to the optimal information also listed below:

- o **Minimal** – Review of present demographic information

  Optimal – Review of information from last 10 years, and projected information over the next 5-8 years

- o **Minimal** – Review of present economic information

  Optimal – Review of last 10 years and projected over the next 5-8 years

- o **Minimal** – Description of present influential circumstances in the state (such as reduced federal funding for various agencies, major

reorganization of state agencies, budget crisis, new industry, opening on new schools or colleges)

Optimal – Description of past (last 10 years) and projected (over the next 5-8 years) influential circumstances

- **Minimal** – A listing of present assets and resources in the state (including description of existing efforts to prevent/address sexual violence)

  Optimal – A listing of past (10 years) and projected (over the next 5-8 years) assets and resources in the state

- **Minimal** – Separate profiles for each major region or county within your state (depending on size of state)

Current Prevention Activities at the State and Local levels Assessments

The prevention program assessments should include:

- an assessment of current state and local RPE funded prevention programming (primary and/or secondary), refer to the Prevention Concepts and Principles section for prevention definitions; and
- an assessment of current RPE funded informational and/or education materials.

CDC expectations for prevention program assessment implementation are:

- **Minimal** – assessment of RPE funded programs

  Optimal – assessment of both RPE funded and non-funded programs

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Helpful Hint: Informational materials should be connected to larger prevention efforts and be prevention focused. Refer to the Enhancement of Legislatively Approved Prevention Activities, Preparation of informational materials enhancement assessment questions section for additional guidance on assessing informational and education materials.

Tools and/or Resources

The below tools collaboratively developed by representatives from CDC, MPR, Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER) Cooperative Agreement[4] grantees, RPE grantees and sexual assault coalitions were developed to aid in the assessment of prevention programming:

- **Primary Prevention Activities Among Rape Prevention and Education (RPE) Funding Recipients Questionnaire** (**Appendix G**);
- **Primary Prevention Activities Among Organizations Without Rape Prevention and Education (RPE) Funding Questionnaire** (**Appendix H**); and,
- **State Level Interview Guide (Appendix I**)

Helpful Hint: The above assessments could also be used to identify current RPE funded primary prevention informational and/or educational materials e.g. curricula being used or developed by adding select questions to the assessments.

Please Note: The tools referenced above are not required; they are provided as a resource.

Programmatic and Leadership Capacity Assessment

The focus of these assessments is to provide information related to the capacity definitions provided below e.g. organization's commitment to and supportive of primary prevention; commitment of resources for prevention programming; mission statement includes ending, preventing or eliminating sexual violence; primary prevention is discussed in staff meeting.

These assessments should include:

- an assessment of current state and local level prevention programming capacity; and,
- a SWOT (strengths, weaknesses, opportunities, threats) analysis which includes assessment of management/leadership support to implement primary prevention strategies/programs.

[4] EMPOWER is three year cooperative agreement awarded to four states and a MOU with two states to build individual and system capacity for prevention, planning, and evaluation of sexual violence primary prevention programming.

Individual (Local) Prevention Capacity[5] - The knowledge, skills, resources, and motivation necessary to provide strategies that are likely to lead to a reduction in incidence of sexual violence within the community they serve.

Individual (State) Prevention Capacity - The knowledge, skills, resources, and motivation necessary to promote a statewide operating environment that supports the development and maintenance strategies, policies, procedures, practices and resources that are likely to lead to a reduction in the incidence of sexual violence.

Tools and/or Resources

The optional **Sexual Violence Prevention System Capacity Assessment (Appendix J)** can be used to assess:

- local prevention programming capacity; and,
- management/leadership support to implement primary prevention strategies/programs.

No other specific tools have been developed to assess programmatic capacity, however questions could be added to the tools below:

- **Primary Prevention Activities Among Rape Prevention and Education (RPE) Funding Recipients Questionnaire (Appendix G)**;
- **Primary Prevention Activities Among Organizations Without Rape Prevention and Education (RPE) Funding Questionnaire (Appendix H)**; and,
- **State Level Interview Guide (Appendix I)**

Please Note: The tools referenced above are not required; they are provided as a resource. Please see the next section for a prevention system capacity definition.

Data System Collection and Capacity Assessments

Data collection is extremely important to completing a State Profile as well as providing a foundation for identifying and selecting universal and selected populations. These populations are where the prevention programming will be focused.

The data system capacity assessments should include:

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[5] The individual state and local prevention capacity definitions are adapted from the CDC-DELTA/EMPOWER Instrument Development Work Group

- a state data and surveillance assessment and analysis; and,
- a state funding assessment and analysis.

CDC Expectations for Data Content of State Assessments

CDC expects grantees and their SVPP committees to collect the **minimal data components** listed in the below three categories to put into their state profiles. If grantees and their SVPP committees have additional resources and/or interest, they could collect up to the optimal data[6] listed below:

1. Data are presented on the magnitude of sexual violence in the state including:
   - **Minimal** – Data describing the magnitude of sexual violence in the state that reflect a critical analysis of multiple sources of data, including local data (emergency room reports), state data (Youth Behavior Risk Factor Survey), and national data (National Violence Against Women Survey)
   - **Minimal** – Magnitude of sexual violence is examined for sub-populations in the state with special emphasis on diversity related to age, gender, ethnicity, sexual orientation, and socioeconomic status, disability status, acculturation status, and geographic location
   - Optimal – Newly collected data about magnitude of sexual violence e.g. surveys, focus groups, key informant interviews
2. Data are presented on risk and protective factors that contribute to sexual violence in the state including:
   - **Minimal** – Data describing risk and protective factors of sexual violence across the social ecology that reflect a critical analysis of multiple sources of data, including local agency (police department, health department), state (Behavioral Risk Factor Surveillance Survey), and national (World Report on Violence and Health)
   - **Minimal** – Risk and protective factors of sexual violence across the social ecology are examined for sub-populations in the state with special emphasis on diversity related to age, gender, ethnicity, sexual orientation, and socioeconomic status, disability status, acculturation status, and geographic location

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[6] Grantees may not use more than 2% of the RPE award received each fiscal year for surveillance or prevalence studies

- Optimal - Newly collected data about risk and protective factors of sexual violence across the social ecology e.g. surveys, focus groups, key informant interviews

- **Minimal** – Using data to select populations at the greatest risk for perpetrating or experiencing sexual violence are identified

3. Thinking critically and interpreting all data that includes an assessment of:

   - Strengths

   - Limitations

   - Gaps

   - What has been learned and any conclusions reached regarding sexual violence within the state

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Tools and/or Resource

The optional **Sexual Violence Prevention System Capacity Assessment (Appendix J)** can be used to assess:

- state data and surveillance assessment and analysis;

- state funding assessment and analysis;

- management/leadership support to implement primary prevention strategies/programs (e.g. SWOT [strengths, weaknesses, opportunities, threats] analysis)

- sexual violence prevention system (optional)

Please Note: The tool referenced above is not required; provided as a resource.

Evaluation Assessment

The evaluation assessment should include:

- an assessment of current evaluation capacity and evaluation efforts being conducted

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Tools and/or Resources

To assess the current evaluation capacity, tools that could be used include:

- **Primary Prevention Activities Among Rape Prevention and**

Education (RPE) Funding Recipients Questionnaire (Appendix G); and,

- **Sexual Violence Prevention System Capacity Assessment (Appendix J)**

Please Note: The tools referenced above are not required; they are provided as a resource.

Training and Technical Assistance (TA) Assessments

The training and technical assistance (TA) assessments will help grantees and their SVPP committees build state and local level capacity for understanding, creating buy in, and implementing sexual violence primary prevention programs.

For the purposes of this cooperative agreement the below draft capacity definitions apply:

Organizational (Local) Prevention Capacity [7]- The structures, processes, strategies, resources, and willingness necessary for this entity to provide strategies and promote policies that are likely to lead to a reduction in the incidence of sexual violence within the community it serves.

Organizational (State) Prevention Capacity - The structures, processes, training and technical assistance activities, resources, and willingness necessary for this organization to promote a statewide operating environment that supports the development and maintenance of programs, policies, procedures, strategies, activities, and resources that are likely to lead to a reduction in the incidence of sexual violence.

These training and TA assessments should include:

- assessment and identification of state health department and potential partners to provide training and technical assistance to state and local programs on prevention programming and evaluation

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Tools and/or Resources

No other specific tools have been developed to assess training and technical assistance, however questions could be added to the tools referenced below:

- **Primary Prevention Activities Among Rape Prevention and Education (RPE) Funding Recipients Questionnaire (Appendix**

[7] The organizational state and local prevention capacity definitions are adapted from the CDC-DELTA/EMPOWER Instrument Development Work Group

G);

- **Primary Prevention Activities Among Organizations Without Rape Prevention and Education (RPE) Funding Questionnaire (Appendix H)**; and,

- **State Level Interview Guide (Appendix I)**

The **Sexual Violence Prevention System Capacity Assessment (Appendix J)** could be used to assessment organizational prevention capacity.

Please Note: The tools referenced above are not required; they are provided as a resource.

Optional Prevention System Capacity Assessment

The responsibility to prevent sexual violence should not belong to any singular organization or group. The Sexual Violence Primary Prevention System[8] is a network of organizations[9] and individuals at the state and/or community level that supports and expands the work of the 4-step public health approach[10] to addressing sexual violence.

An assessment of the Sexual Violence Prevention System is **highly recommended**. The sexual violence prevention system is described and assessed by the seven dimensions of:

- leadership (recognized authority, legitimacy, accountability or influence);
- strategic planning;
- community focus;
- human resources;
- system operations (organizations, strategies, programs and processes);

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[8] Definition developed CDC GTO Development Team and MPR Workgroup

[9] Coalitions, partnerships, local or state government agencies, or nonprofit agencies and their respective stakeholders

[10] Step 1: Define and Measure the Problem; Step 2: Identify Risk and Protective Factors; Step 3 Identify Effective Strategies; Step 4: Disseminate Effective Strategies

- o information (data collection, analysis, and management); and,
- o results/outcomes documented

Additional information about prevention system capacity can be found in GTO IPV/SV Step 5.

Tools and/or Resource

The **Sexual Violence Prevention System Capacity Assessment and Administration Protocol (Appendix I)** could be used to assess the prevention system capacity.

Please Note: The above assessment is an optional assessment; **it is not required**. The above tool is provided as a resource.

Tools and/or Resources

Refer to the archived April 28th or April 30th, 2007 presentation(s), web seminar(s) and/or presentation attachments conduced by CDC and EMPOWER grantees on *Comprehensive Assessments* for additional guidance on state assessments.

An archive copy of the *Comprehensive Assessments* web seminar(s) can be accessed on the NSVRC website, www.nsvrc.org. Contact your Project Officer if you have questions on how to access the archived web conference.

What to do with the Assessment Information

State Profile

Once the assessment data has been gathered; the next step is to create a state profile. A state profile is a comprehensive description of people, conditions, and resources in your geographic area of interest.

The state profile describes the people who live in your state, conditions such as indicators of well-being of children and families who live in your state and resources such as skills, organizations, funding, and assets of a state as they were in the past, as they are currently and as they may be in the future.

A state profile typically includes information about:

- o demographics e.g. number of individuals and family household, age distribution, sex distribution, racial/ethnic composition, number of people with disabilities, distribution of urban, rural, immigrant/refugee;

- economics e.g. annual household income, major employers, unemployment rates;

- other information (individual and community level resources and assets, prevention programming);

- sexual violence magnitude data; and,

- risk and protective factor data.

The completed state profile should be used as a reference point for the rest of the needs and resource assessment. This may help to reveal special populations or conditions that the SVPP committee may need to explore further.

Goal and Outcome (Objective) Statements - GTO IPV/SV Step 2

Introduction

This section includes information on:

- CDC expectations for goal and outcome (objective) statements;
- goal and outcome statement definitions; and,
- developing and prioritizing goal statements for universal, selected and prevention system (optional).

CDC Expectations

Information gathered from assessments and the State Profile (GTO IPV/SV Step 1) should be used to inform the goal and outcome (objective) statement development process.

Well planned and well written goals and outcome (objective) statements will help with the development, implementation and evaluation of program strategies and programs.

In addition, goals and outcome statements will provide the foundation upon which to choose prevention strategies. For additional information regarding prevention strategies and programs refer to the Evidence – Supported Strategies, GTO IPV/SV Step 3.

CDC expects SVPP committees to include goals and outcome statements that are geared towards preventing both first time perpetration and victimization; the goals and outcome statements should be appropriate balance between perpetration and victimization prevention.

Recommendation: For broad planning (strategic planning to end sexual violence that goes beyond RPE funding), consider developing specific goals for your universal population, selected populations **and** to build prevention system capacity.

Reminder

The Sexual Violence Prevention Planning Committee should have a vision statement that was created in GTO IPV/SV Step 1. If the planning committee does not have an agreed upon vision statement, this should be done before developing goal and outcome statements.

The vision statement is the Committee's dream of what a community or state would look like if it was free of sexual violence. An agreed upon vision

statement will help the planning committee to develop goals and outcomes statements that support the vision.

Helpful Hint: Vision statements should drive the information that is collected in the needs and resource assessments/state assessment. The needs and resource assessments/state assessment and completed State Profile should drive the goal and outcome statements development process.

Goals and Outcome Statements

Goals and outcome statements are different than vision statements.

Goal Statements Definition

Goal statements reflect attainable and ambitious change that you believe your state can actually accomplish. Goals describe what you want to accomplish or change, not what you want to implement.

Phrases similar to below are used to develop goal statements:

- "To reduce…."
- "To increase…"
- "To eliminate…"
- "To improve…"

Phrases **not to use** in goal statement development are:

- "To implement…"
- "To start…"

Helpful Hint: **Goals focus on change, not activities.** A common mistake when writing goals is to describe a program activity or strategy instead of the knowledge, attitude or behavior changes that is to result from that activity or strategy.

Outcome Statements Definition

Outcome statements are the specific, measurable statements that let you know when you have reached your goals. Outcome statements describe:

- Who or what will change?
- By how much?
- By When?
- How the change will be measured?

A helpful acronym to remember when writing outcome statements is ABCDE (Chinman et. al). Outcome statements should include:

- A – Audience (The population for whom the desired outcome is intended)
- B- Behavior (What is to happen? A clear statement of expected behavior change)
- C- Condition (By when is the change expected to occur?)
- D – Degree (How much change is expected?)
- E – Evidence (How will the change be measured?)

Developing Goal and Outcome Statements

Goal Statements

SVPP committees should develop goals and outcome statements to address the needs of universal and selected populations focusing on reducing risk factors and promoting protective factors associated with sexual violence across the multiple levels of the social ecological model.

The needs and resources assessment/state assessment and developed State Profile will provide the planning committee the information needed to develop goal statements.

Helpful Hint: Goal statements should focus on reducing risk factors and promoting protective factors at multiple levels of the social ecology for universal and selected populations. The goal statements should address a 3-8 year time frame and focus on being changed based.

CDC Expectations for Goal Statements

At a minimum, CDC expects SVPP committees to develop at least one goal related to the needs of the identified populations:

- **Minimal** - universal populations;
- **Minimal** - selected populations;

CDC **highly recommends** SVPP committees to develop goals to build prevention system capacity.

- Optimal - prevention system capacity

Refer to the Prevention Concepts and Principles section for additional information regarding the universal and selected population's prevention concepts.

Refer to the Information on Planning Components (GTO IPV/SV Step 1) section for information on prevention system capacity.

Outcome Statements

Outcome statements should describe how you will measure your progress toward reaching the developed goals. In addition, outcome statements should make it easier to evaluate identified and prioritized program strategies and/or programs.

Please Note: Outcome statements can be considered benchmarks that will let you know how you are progressing toward your goal. If using GTO IPV/SV, this will occur in Steps 7-9.

Helpful Hint: **Appendix K** provides **examples of ABCDE written outcome statements**. In addition, remember to establish outcome statements that are logically related to the goal.

Optional: Goals and outcome statements related to prevention system capacity should describe changes in policies, as well as define changes in organizational capacity (structures, processes, resources, collaborations, and motivations) and/or broader system capacity elements to prevent sexual violence at the state or community level.

Goals and outcome statements developed to increase prevention system capacity should focus on improving your state's or community's ability to plan, implement, and evaluate primary prevention strategies to reduce sexual violence.

Prioritizing Goal Statements

When the Sexual Violence Prevention Planning Committee has brainstormed the goals, more than likely there will be more goals than can feasibly be addressed in the primary prevention plan. Thus, the SVPP committee will need to prioritize the goals that should go in the prevention plan.

During the prioritization process, the planning committee should consider:

- how many goals can feasibly be addressed within the plan timeframe;
- the resources that are available to address the goals;
- the goals of your existing strategies (so you do not duplicate your current efforts); and,
- the needs of underserved and/or marginalized populations and groups.

Helpful Hint: Develop criteria to help guide the goal statement prioritization process. Please remember that goal prioritization process includes the consideration of the burden of sexual violence in the selected populations at highest risk in the community and/or state.

Universal and Selected Population Goal Statements

A first step in prioritizing goals for universal and selected populations is by considering whether or not the goals address conditions, risk factors and protective factors that are important and modifiable.

Helpful Hint: When the SVPP committee has identified and prioritized the goals and outcome statements, the next step should to be draft a timeline of the goals and outcomes statements to assess the feasibility of achieving your goals and outcomes in the plan timeframe. Determine which goals and outcomes may need to precede other goals and outcomes.

Optional Prevention System Capacity Goal Statements

A first step in prioritizing goals for building the capacity of your prevention system is to also consider whether or not the goals address organizational resources (structures, processes, resources, willingness/motivation, and activities) or system (leadership, strategic planning, community focus, human resources, system operations, information, and results/outcomes documented) elements that are important and changeable.

For additional information on prevention system capacity, refer to GTO IPV/SV Step 5.

Evidence – Supported Strategies - GTO IPV/SV Step 3

Introduction

This introduction provides an overview of GTO IPV/SV Step 3 - Evidence-Supported Strategies[11], the importance of this step, and key terms used. With this information, the SVPP committee would understand the various options they have to address the goals that were developed for their universal and selected populations.

Overview

The needs and resources assessments in GTO IPV/SV Step 1 helped to develop preliminary goals and outcomes for your chosen universal and selected populations as well as prevention system capacity (optional) in GTO IPV/SV Step 2.

By now the SVPP committee should have:

- Completed a state profile
- Identified needs of universal and selected populations
- Identified needs of your prevention system (optional)
- Identified state and community resources
- Identified priority goals and outcomes for universal and selected populations and for your prevention system (optional)

The implementation of GTO IPV/SV Step 3 will assist the SVPP committee in:

- understanding what sexual violence prevention strategies are;
- understanding what evidence means for sexual violence primary prevention;
- understanding the importance of choosing strategies with the strongest evidence to address the goals and outcomes developed for your universal and selected populations in GTO IPV/SV Step 2;
- understanding prevention strategy fidelity and adaptation issues;
- identifying an initial set (at least 2) of evidence-supported prevention

[11] Information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual. The information provided are the major concepts needed to implement the process. The following sections will be updated and revised as the completed steps become available.

strategies to address each of the goals and outcomes for your universal and selected populations in GTO IPV/SV Step 2; and,

- organizing and documenting your initial set of evidence-supported prevention strategies into a logic model.

Helpful Hint

If using GTO IPV/SV these are the steps where the building of the new RPE activities logic model mentioned in the **Rape Prevention and Education (RPE) Cooperative Agreement, Revised Benchmarks for Success and Recommended Timelines dated June 25, 2008 (Appendix F)** occurs.

Appendix L provides a recommended **GTO format for Universal and Selected populations logic model development**. In addition, the logic model developed using GTO IPV/SV will look different than the RPE activities models.

For additional information on logic models and/or the RPE activities logic model, refer to the RPE Theory and Activities Models and Program Planning section.

Please Note: If creating a statewide plan that's broader than the RPE program, please create two logic models. The first logic model should be for the RPE program only. The second logic model should be for the broader statewide sexual violence efforts.

Why this Step is important?

Maintaining a clear connection among the needs identified in GTO IPV/SV Step 1, the goals and outcomes developed in GTO IPV/SV Step 2, and the evidence-supported prevention strategies that will be identified GTO IPV/SV Step 3 increases the overall strength of the Comprehensive Prevention Plan and the possibility that the SVPP committee will achieve the goals and outcomes developed in GTO IPV/SV Step 2.

By using the information provided in GTO IPV/SV Step 3, the SVPP committee will also gain:

- increased buy-in from stakeholders as stakeholders assist in identifying prevention strategies with the strongest supporting evidence;
- increased chances of preventing sexual violence because you are using strategies with the strongest supporting evidence;

- more effective use of available resources as evidence-supported strategies are more likely to lead to the goals and outcomes developed in GTO IPV/SV Step 2;
- an understanding of potential facilitators and barriers to implementation and evaluation of identified strategies; and,
- more clearly defined prevention strategies and/or programs that can inform process and outcome evaluations as well as the continuous quality improvement activities will be planned and implemented in GTO IPV/SV Steps 7, 8, and 9.

Please Note: If using GTO IPV/SV, the development of the evaluation plan begins with GTO IPV/SV Steps 7and 8. These GTO IPV/SV steps should identify specific short term and intermediate benchmarks that demonstrate the progress and success in implementing the identified strategies and/or programs. These steps should be implemented in Year 3 or 4 of the cooperative agreement.

In addition, short term and intermediate outcome measures and indicators based on the **RPE Theory and Activities models (Appendix D)** will be identified by CDC through the RPE Indicators Project and adopted by grantees. These measures and indicators will be available Winter 2008.

GTO IPV/SV Steps 3-5 – an Iterative Process

If using GTO IPV/SV, the SVPP committee should consider implementing GTO IPV/SV Steps 3-5 as a cluster instead of individual steps. GTO IPV/SV Steps 3-5 can help SVPP committees think and act critically through the identification and selection of evidenced supported prevention strategies in the absence of strong evidence base for sexual violence prevention.

GTO IPV/SV Steps 3-5 fit together **and** act independently to aid SVPP committees to:

- identify evidence supported prevention strategies (Step 3);
- examine community and state context (Step 4); and,
- identify capacities (Step 5) for implementation.

Information for each step will inform and build upon the next step creating an iterative process. At each iteration, modifications are made and new information and capacities may be gained. Information for each of these steps will need to be considered at the same time in order to complete the steps. Rarely would the SVPP committee work through these steps linearly.

Once GTO IPV/SV Steps 3-5 are completed, the SVPP committee will be

ready to bring all the information that has been gathered together into their Comprehensive Prevention Plan for Sexual Violence that will be completed in Step 6.

Important Terms

Here are some of the key terms[12] to become familiar with while reading this section.

Activities

The processes, tools, events, technology, and actions required to implement a strategy. Common activities include developing a product (e.g. brochure), providing training, developing an implementation plan, and building infrastructure (e.g., structures, relationships, and capacity).

For example, a social marketing campaign is a strategy that includes many activities, one being the pre-testing of materials with the representatives from the intended audience to determine relevance, comprehensibility, motivational characteristics, and impact.

Adaptation

Includes four types of modification to a strategy, whether deliberate or accidental:

(1) deletions or additions (enhancements) of program components,

(2) modifications in the nature of the components that are included,

(3) changes in the manner or intensity of administration of program components called for in the program manual, curriculum, or core components analysis, or

(4) cultural and other modifications required by local circumstances (SAMHSA, 2002)[13].

[12] Key terms developed and/or adapted by the CDC GTO IPV/SV Development Team in the development of the GTO IPV/SV. In addition, the information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual.

[13] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

Evidence-supported Strategies	Strategies that have documented evidence regarding their: a. proven ability to prevent sexual violence based on research evaluations of their outcomes; b. demonstrated ability to reduce risk factors/increase protective factors associated with sexual violence based on research evaluations of their effect on risk/protective factors; or, c. potential ability to prevent sexual violence based on a scientifically validated theory; theoretical, structural, or content similarity to other evidence-based or informed strategies; prevention principles; or sexual violence content.
Fidelity	Actual strategy implementation matches how the strategy was intended to be implemented by: (1) the original developer and (2) the SVPP committee after any needed adaptations
Prevention Strategy	An approach that works to prevent sexual violence from initially occurring. Prevention strategies do not include strategies that work to prevent a re-occurrence of sexual violence (i.e., arrest) or to ameliorate the harm caused by sexual violence (i.e. crisis counseling). Generally, prevention strategies employed at a specific level of the social ecology address risk factors and protective factors associated with universal and selected populations at that specific level of the social ecology.
Program	The combination of several strategies designed to deliver reinforcing messages to one or more intended populations in a variety of settings.
Program Evaluation	An appraisal of a strategy or program to demonstrate its worth or effectiveness and to make recommendations **for improvements**. Program evaluation helps in making comparisons with different types of strategies and/or programs, looking at achievements; cost-effectiveness, appropriateness; and if funded, whether requirements for funding were met.
Research Evaluation	Outcome evaluation of a strategy or program that incorporates an experimental design utilizing a control group whereby a hypothesis is tested in order **to prove** that a strategy is effective.

Strategy

An approach intended to reduce violent behavior, such as social skills training, mentoring, social marketing or policy changes. These approaches often include multiple activities that together are intended to achieve goals or results at a specific level of the social ecology.

For example, a social marketing campaign is a community-level strategy intended to prevent violence that includes many activities such as selecting media outlets and materials, developing and pre-testing materials, implementation, and assessing feedback.

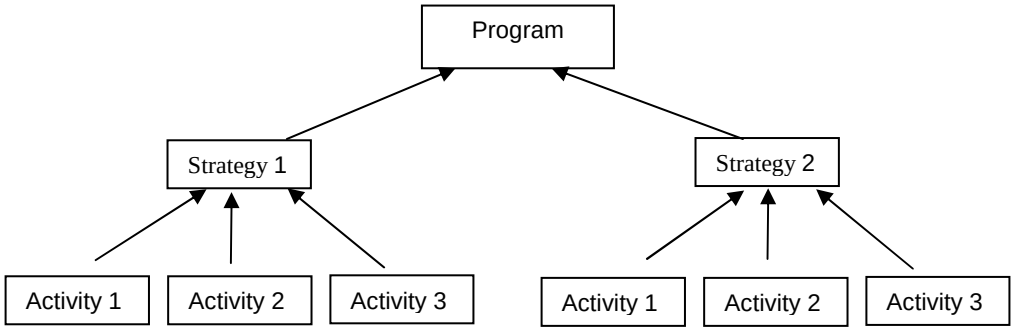
Relationship between a Program, Strategies, and Activities

Understanding the difference between a strategy and an activity is important for implementation as well as evaluation purposes. This section defines the differences between them.

Program, Strategies and Activities

Figure 3 below shows how programs, strategies, and activities are linked together.

Figure 3: The link between programs, strategies and activities



Helpful Hint: Programs are the combination of several strategies designed to deliver reinforcing messages to one or more intended populations in a variety of settings.

A comprehensive prevention program is the combination of complementary and synergistic prevention strategies across the levels of the social ecology

that address the needs of a universal or selected population.

For additional information on this, please see the Prevention Concepts and Principles guidance document section.

Strategies and Activities

Strategies should link back to the needs (GTO IPV/SV Step 1) and goals (GTO IPV/SV Step 2) developed by the SVPP committee for the universal or selected populations. Activities should support the implementation of these strategies.

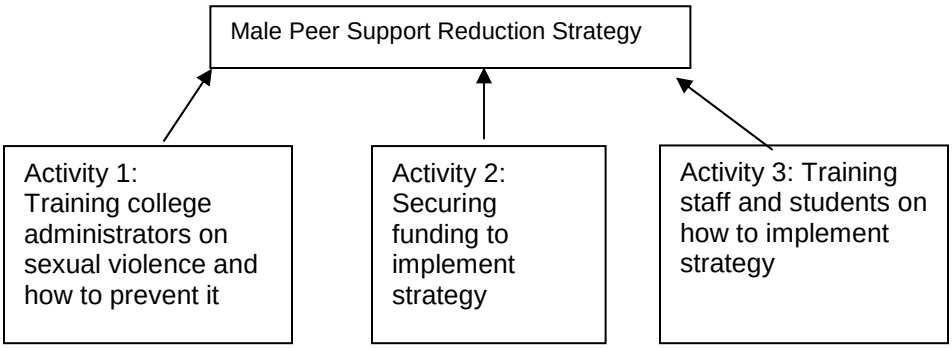
For example, the SVPP committee is interested in changing a relationship level risk factor for sexual violence among college age men: peer support for sexual aggression.

NEED (GTO Step 1)	RELATIONSHIP LEVEL GOAL (GTO Step 2)
Men enrolled as students on college campuses with the highest rates of sexual violence in our state reported high levels of peer support for sexual aggression according to surveys and focus groups.	To decrease peer support for sexual aggression on college campuses.

Strategies to address the desired outcome could be social skills trainings or social marketing. Activities could be training administrators and editorials in the college newspapers.

Figure 4 shows the links between a male peer support reduction strategy and some activities that would support its implementation.

Figure 4: Many Activities Support a Strategy



Why are Strategies the Focus?

If using GTO IPV/SV, the guide emphasizes building effective prevention strategies that over time, as resources become available and capacity is increased, are combined into a comprehensive prevention program.

Thus, GTO IPV/SV encourages states and communities to implement one strategy for a universal or selected population well prior to adding a second complementary and synergistic strategy. The overall process of building a comprehensive prevention program might follow this path:

1. GTO IPV/SV Steps 1-6: Develop a plan for implementation of the prevention strategy;

2. GTO IPV/SV Step 7: Implement the prevention strategy and conduct a process evaluation to ensure it is being implemented as intended (i.e., with fidelity);

3. GTO IPV/SV Step 8: Conduct an outcome evaluation to determine if the strategy is producing the expected results; and,

4. GTO IPV/SV Step 9: Using continuous quality improvement, decide how to improve the current strategy and/or complement the current strategy with a synergistic strategy at a different level of the social ecology (i.e., build the next level of a comprehensive prevention program).

Please Note: If using GTO IPV/SV, Steps 7, 8 and 9 should be implemented in Year 3 or 4 of the cooperative agreement.

In addition, through the development of the **RPE Theory and Activities models (Appendix D)**, meaningful short term and intermediate outcome measures and indicators will be identified by CDC through the RPE Indicators Project and adopted by grantees. These measures and indicators will be available Winter 2008.

Helpful Hint:

As discussed earlier in the Prevention Concepts and Principles section, to increase the effectiveness of RPE programs/strategies, the strategies/programs should address several levels of the social ecological model.

Implementing comprehensive prevention programs addresses the complex interplay of risk and protective factors with a complementary mix of strategies across the various levels of the social ecology. Strategies that focus only on one level of the social ecology are unable to address this complex interplay of risk and protective factors.

Reminder: Please remember proposed and/or prioritized RPE strategies and/or programs should also align with CDC Goals for Healthy People in Every Stage of Life, Healthy People in Healthy Places and the proposed National PART Objective.

Refer to relevant sections of the guidance document for additional information.

Understanding What Evidence Means for Sexual Violence Primary Prevention[14]

Overview

Evidence-based programming is a core tenet of the public health approach utilized by the CDC. As all evidence has its limitations, CDC encourages grantees to utilize the best available evidence when developing prevention programming and strategies.

This section describes how:

- the evidence supporting the use of various prevention strategies occurs on a continuum; and,
- prevention strategies can be classified into three categories based on the strength of evidence associated with them.

Evidence of a strategy's ability to prevent first-time perpetration or victimization of sexual violence is an important factor to consider when choosing a prevention strategy. SVPP committees need an adequate understanding of the evidence supporting the use of a particular strategy in order to:

1. understand what outcomes can reasonably be expected from a particular strategy;
2. know how to strengthen the evidence supporting the use of strategies without evidence of their ability to produce the desired outcomes; and,
3. adequately assess how adaptations to a particular a strategy may affect the outcomes it produces.

SVPP committees with a sufficient understanding of the evidence supporting the use of a particular strategy can adequately describe the expected outcomes of a particular strategy and how the resources used to support a particular strategy are a good investment for the state or community implementing the strategy.

[14] Key terms developed and/or adapted by the CDC GTO IPV/SV Development Team in the development of the GTO IPV/SV. In addition, the information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual.

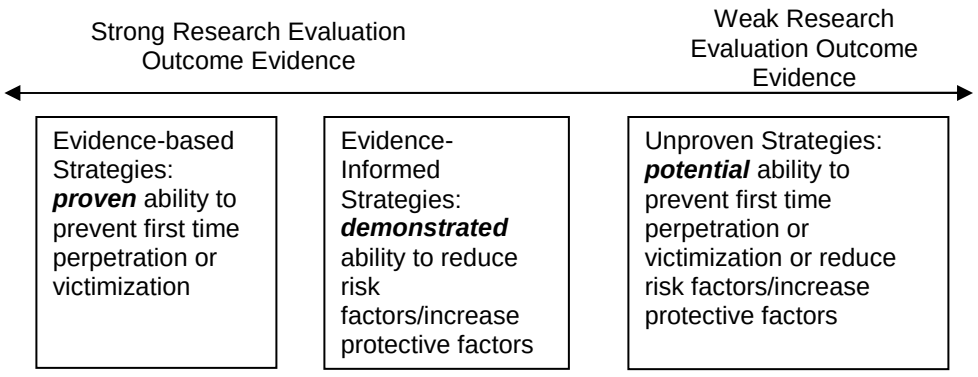
Sexual Violence Prevention Strategy Evidence Continuum

The strength of evidence regarding a strategy's ability to prevent first-time perpetration or victimization of sexual violence exists on a continuum based on the quality of the outcome evaluations conducted. At one end of this continuum are strategies that have the **proven ability** to prevent first-time perpetration or first time victimization of sexual violence based findings from research evaluations (e.g., outcome evaluations with an experimental design utilizing control group).

At the other end of the evidence continuum are strategies that do not have the *proven* ability to prevent first-time perpetration or victimization of sexual violence due to the lack of findings from research evaluations. Strategies at this end of the continuum may have the **potential ability** to prevent sexual violence depending on the quality of other evidence used to support their implementation.

Figure 5 provides an overview of the evidence continuum and the three categories of strategies

Figure 5: Sexual Violence Prevention Strategies Evidence Continuum



Evidence-based strategies

On this evidence continuum, the strongest evidence comes from research evaluations that ***prove*** a strategy's ability to prevent first-time perpetration or first time victimization. **Strategies with this type of evidence associated with them are referred to as evidence-based strategies.**

Evidence-based strategies are considered to be the strategies most likely to prevent first-time perpetration or victimization of sexual violence when implemented with fidelity.

As mentioned earlier in the document, fidelity is defined as actual strategy implementation matching how the strategy was intended to be implemented by (1) the original developer of the strategy and (2) the SVPP committee after any needed adaptation.

In addition, evidence-based strategies may have also been subjected to program evaluation for the purpose of strategy improvement by organizations implementing them. Program evaluation may provide additional information regarding implementation issues.

Evidence-based strategies are also widely available to practitioners, states and communities through manuals, websites or other materials that describe how to implement the strategy.

Benefits of using Evidence-based Strategies

The benefits of using evidence-based strategies are:

1. Evidence-based strategies have a high likelihood of preventing first-time perpetration or victimization of sexual violence when implemented with fidelity.

2. The findings from research evaluations provide sufficient evidence to support the use of an evidence-based strategy. Unlike unproven strategies, there is no need to strengthen the evidence supporting the use of an evidence-based strategy.

3. Manuals or implementation materials are available, free of charge or through purchase.

4. Financial and staff resources are not needed to develop a new strategy.

5. Financial and staff resources can be focused on any needed adaptations, strategy implementation, and program evaluation.

Limitations of Using Evidence-based Strategies

The limitations of using evidence-based strategies are:

1. Evidence-based strategies may not be compatible with a state's or community's context (see Community and State Context GTO IPV/SV Step 4 section of guidance document for additional

information) and may need to be adapted[15].

2. Evidence-based strategies may require capacities at the individual, organizational, and other levels beyond those currently available (see Capacity GTO IPV/SV Step 5 section of guidance document for additional information).

3. Evidence-based strategies may not sufficiently incorporate a health promotion approach to primary prevention, but instead may focus on deterrence and risk reduction approaches to prevention. For additional information on this, refer to the Evidence Supporting the Use of Unproven Strategies section of this Step.

Fidelity/ Adaptation Issues of Evidence-based Strategies

The fidelity/adaptation issues related to using evidence-based strategies are they:

1. may seek to adapt an evidence-based strategy to be more compatible with state or community contexts. How to adapt such strategies and still remain faithful to the overall intent of the strategy (i.e. maintain fidelity) is addressed in GTO IPV/SV Step 4 Community and State Context.

2. may seek to adapt or improve evidence-based strategies based on their own program evaluation results as part of the improvement process. **Please Note:** If using GTO IPV/SV, this will be part of GTO IPV/SV Step 9 the continuous quality improvement process. This step should be implemented in Year 3 or 4 of the cooperative agreement.

Tools and/or Resources

An available IPV/SV evidence-based program is the Safe Dates Program which is a school-based strategy to prevent teen dating violence for 8th and 9th graders that includes a play, a 9 session curriculum and a poster contest.

Due to the current state of the science for sexual violence prevention research evaluations, this is the only evidence-based program available.

Tools and/or Resources

Seek out peer reviewed journals in order to identify any new or emerging evidence-based strategies for the prevention of sexual violence.

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[15] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

Evidence-informed strategies

The second strongest evidence comes from research evaluations that ***demonstrate*** a strategy's ability to reduce risk factors/increase protective factors associated with sexual violence. **Strategies with this type of evidence associated with them are referred to as evidence-informed strategies.**

Evidence-informed strategies may have also been subjected to program evaluation for the purpose of strategy improvement by organizations implementing them. Program evaluations may provide additional information regarding implementation issues.

Evidence-informed strategies are widely available to practitioners, states and communities through manuals, websites or other materials that describe how to implement the strategy.

Benefits of using Evidence-informed Strategies

The benefits of using evidence-informed strategies are:

1. Evidence-informed strategies have a high likelihood of reducing risk factors/increasing protective factors associated with sexual violence when implemented with fidelity.
2. The findings from research evaluations provide sufficient evidence to support the use of an evidence-informed strategy. Unlike unproven strategies, there is no need to strengthen the evidence supporting the use of an evidence-informed strategy.
3. Manuals or implementation materials for evidence-informed strategies are available free of charge or through purchase.
4. Financial and staff resources are not needed to develop a new strategy.
5. Financial and staff resources can be focused on any needed adaptations, strategy implementation, and program evaluation

Limitations of using Evidence-informed Strategies

The limitations of using evidence-informed strategies are:

1. Evidence-based strategies may not be compatible with a state's or community's context (see Community and State Context GTO IPV/SV Step 4 section of guidance document for additional information) and may need to be adapted.

2. Evidence-based strategies may require capacities at the individual, organizational, and other levels beyond those currently available (see Capacity GTO IPV/SV Step 5 section of guidance document for additional information).

3. Evidence-informed strategies may not sufficiently incorporate a health promotion approach to primary prevention, but instead may focus on deterrence and risk reduction approaches to prevention. For additional information on this, refer to the Evidence Supporting the Use of Unproven Strategies section of this Step.

Fidelity/ Adaptation Issues of Evidence-informed Strategies

The fidelity/adaptation issues related to using evidence-informed strategies are they:

1. may seek to adapt an evidence-informed strategy to be more compatible with state or community contexts. How to adapt such strategies and still remain faithful to the overall intent of the strategy (i.e. maintain fidelity) is addressed in GTO IPV/SV Step 4 Community and State Context.

2. may seek to adapt or improve evidence-informed strategies based on their own program evaluation results as part of the improvement process. **Please Note:** If using GTO IPV/SV, this will be part of GTO IPV/SV Step 9 the continuous quality improvement process. This step should be implemented in Year 3 or 4 of the cooperative agreement.

Tools and/or Resources

Practitioners may identify new or emerging informed strategies through peer reviewed journals.

Unproven strategies

The evidence of a strategy's ***potential*** ability to prevent first-time perpetration or victimization of sexual violence is considered to be weaker than evidence that ***proves*** a strategy's ability to prevent sexual violence or ***demonstrates*** a strategy's ability to reduce risk factors/increase protective factors associated with sexual violence.

The evidence associated with a strategy's ***potential*** ability relies on the best available research and knowledge regarding what has lead to successful behavior or social change in other health issues, while informing this research and knowledge with content specific to sexual violence and community knowledge.

These strategies are referred to as unproven strategies due to the lack of research evaluations that prove their ability to prevent sexual violence or demonstrate their ability to reduce risk factors/increase protective factors.

Where do Unproven Strategies come from?

Due to the state of the evidence regarding sexual violence prevention, most states and communities are currently implementing unproven strategies for the prevention of sexual violence. Unproven strategies originate from many sources; these may include:

- A modified evidence-based strategy. The modified strategy cannot be considered as having a high likelihood of achieving the same outcomes as the original evidence-based strategy due to the modifications and must undergo its own research evaluation that ***proves*** the modified strategy has the ability to prevent sexual violence before it can be considered to be an evidence-based strategy.

- A strategy developed, implemented, and made widely available by a reputable sexual violence organization that has not been subjected to research evaluation that proves its ability to prevent sexual violence or reduce risk factors/increase protective factors associated with sexual violence.

- A strategy that addresses another health issue being utilized to prevent sexual violence and has not been subjected to research evaluation regarding its ability to prevent sexual violence or reduce risk factors/increase protective factors associated with sexual violence.

- A strategy developed by a state, community, or organization to specifically address sexual violence that has not been subjected to research evaluation regarding its ability to prevent sexual violence or reduce risk factors/increase protective factors associated with sexual violence.

Helpful Hint: The **key criteria** for being classified as an unproven strategy is that the strategy to be implemented **has not been subjected to research evaluation that proves it has the ability** to prevent sexual violence or that demonstrates its ability to reduce risk factors/increase protective factors associated with sexual violence.

Benefits of Using Unproven Strategies

The benefits of using unproven strategies are:

1. Unproven strategies may be considered to be more compatible with a state's or community's context than un-adapted evidence-based or evidence-informed strategies.

2. Unproven strategies may be more compatible with a state's or community's current capacities.

3. A health promotion perspective regarding primary prevention can be considered in the development/strengthening of these strategies. For additional information on this, refer to the Evidence Supporting the Use of Unproven Strategies section of this Step.

Limitations of Using Unproven Strategies

The limitations of using unproven strategies are:

1. Unproven strategies **do not have** evidence proving or demonstrating their ability to prevent sexual violence or reduce risk factors/increase protective factors associated with sexual violence, respectively.

2. Many unproven strategies may not have manuals or other materials that document how to implement the strategy available free of charge or through purchase. Thus, what strategy is actually being implemented is unknown due to lack of sufficient documentation.

3. The financial and staff resources needed to develop, document, or adapt these strategies are often substantial.

4. Additional resources will be needed for implementation and program evaluation.

Fidelity/ Adaptation Issues of Using Unproven Strategies

The fidelity and adaptation issues for unproven strategies warrant different considerations than for evidence-based and evidence-informed strategies. The fidelity/adaptation issues related to using unproven strategies are:

1. Strengthening the evidence supporting the use of an unproven strategy is the first and most important type of adaptation that can be made to an unproven strategy (this concept will be discussed later in this section). Fidelity to an unproven strategy is less important than strengthening the evidence that supports the use of an unproven strategy.

2. May seek to adapt an unproven strategy to be more compatible with their state or community contexts. How to adapt such strategies to still remain faithful to how evidence adaptations increased the evidence supporting the use of the strategy is addressed in GTO

IPV/SV Step 4 Community and State Context.

3. May seek to adapt or improve evidence-based strategies based on their own program evaluation results as part of the improvement process. **Please Note:** If using GTO IPV/SV, this will be part of GTO IPV/SV Step 9 the continuous quality improvement process. This step should be implemented in Year 3 or 4 of the cooperative agreement.

Tools and/or Resources

Some available unproven strategies/programs that have demonstrated through program evaluation their ability to address sexual violence are:

- Expect Respect
- Men of Strength Clubs

These strategies are referred to as unproven strategies due to the lack of research evaluations that prove their ability to prevent sexual violence or demonstrate their ability to reduce risk factors/increase protective factors related to sexual violence.

Tools and/or Resources

Unproven strategies may be identified through an internet searches and program evaluation reports. Common contents of an Program evaluation Report are:

- Executive Summary
- Program Description
- Evaluation Purposes
- Evaluation Design
- Data Analysis
- Results and Interpretations
- Appendices

The following publications can provide guidance on how to assess program evaluation reports regarding strategies to prevent sexual violence:

U. S. Department of Housing and Urban Development, Office of Policy Development and Research (1997). A Guide to Evaluating Crime Control Programs in Public Housing. Washington, DC: Author. Pp. 8.1-8.13.

Retrieved September 27, 2007 from http://www.ojp.usdoj.gov/BJA/evaluation/guide/documents/chapter_8_reporting_your_find.htm

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Please Note: Program evaluation reports will often not meet the standards of a research evaluation report in terms of sample size used and statistical significance test.

State of the Evidence regarding Sexual Violence Prevention Strategies

Ideally, SVPP committees would have multiple evidence-based and evidence-informed strategies and/or programs at each level of the social ecology from which to choose to address the goals and outcomes developed for their universal and selected populations in GTO IPV/SV Step 2.

Unfortunately, the state of evidence for sexual violence evidence-based and evidence- informed prevention strategies is that these strategies:

1. are few in number;
2. are largely individual and relationship level strategies;
3. have most often been implemented in limited settings, such as schools, which means little is known about how well these strategies translate to other settings; and,
4. have not been evaluated with diverse populations.

Thus at this time, more unproven prevention strategies exist for the prevention of sexual violence than evidence-based or evidence-informed prevention strategies. This state of the evidence is not likely to change any time soon due to the time required to conduct research evaluations that assess the outcomes of a particular strategy and determine whether a strategy is evidence-based or evidence-informed.

What can be Done?

Given this state of the evidence regarding strategies for sexual violence primary prevention, most SVPP committees will be identifying unproven strategies to address the goals and outcomes developed for their universal and selected populations in Step 2.

Hopefully, over time, SVPP committees are able to build comprehensive prevention programs based on a mix of evidence-based, evidence-informed and unproven Strategies as more evidence-based and evidence-informed strategies are identified.

As states and communities build their comprehensive prevention programs, they will have to determine the optimal mix of strategies to include in these programs based on the strength of the evidence associated with various strategies as well as on capacity, resource, and readiness issues.

The key message is for states and communities to continuously strengthen the evidence supporting the use of their chosen strategies through process and outcome evaluation and continuous quality improvement activities. In addition, states should consider including in their prevention plan system capacity goals to garner resources and support for doing this.

When evidence indicates that a strategy is not achieving its goals and objectives, SVPP committees are encouraged to replace it with a strategy that has stronger evidence while taking into consideration capacity, resources, and readiness issues.

When evidence indicates that a strategy is achieving its goals and objectives, SVPP committees are encouraged to start building a comprehensive prevention program by adding a complementary and synergistic strategy at a different level of the social ecology.

Helpful Hint

The strength of evidence associated with a particular strategy can change over time and lead to changes in a strategy's classification on the continuum. For instance, a strategy that falls into the unproven category can undergo a research evaluation that demonstrates its ability to reduce risk factors/increases protective factors associated with sexual violence. This unproven strategy would then become classified as an evidence-informed strategy based on the availability and strength of this new evidence.

Reminder

As part of the identification and documentation process for evidence based/informed or unproven strategies, please remember the strategies selected should align with:

- CDC Goals for Healthy People in Every Stage of Life, Healthy People in Healthy Places; and,
- Proposed National PART Objective.

Refer to the CDC Goals and National PART Objective section for addition information.

Fidelity and Adaptation Issues

How Does Fidelity and Adaptation Relate to the State of Evidence?

If and to what extent should SVPP committees adapt or modify a strategy and how does those modification(s) affect the evidence supporting the use of the strategy. The answers to those questions requires the understanding of:

- what strategy fidelity and adaptation are; and,
- whether the strategy is an evidence-based/evidence-informed strategy or an unproven strategy.

As mentioned earlier, fidelity is defined as actual strategy implementation matching how the strategy was intended to be implemented by (1) the original developer of the strategy and (2) the SVPP committee after any needed adaptation; and, adaptation includes four types of modification to a strategy, whether deliberate or accidental:

1. deletions or additions (enhancements) of program components,
2. modifications in the nature of the components that are included,
3. changes in the manner or intensity of administration of program components called for in the program manual, curriculum, or core components analysis, or
4. cultural and other modifications required by local circumstances (SAMHSA, 2002)[16].

Fidelity and/or Adaptation to an Evidence-based or Evidence-informed Strategy

Fidelity to an evidence-based or evidence-informed strategy is important as the positive results achieved by a specific strategy may only be achieved when implemented under certain circumstances. Adaptation becomes equally important to determine if the appropriate conditions and contexts exist to support those results.

Evidence-based and evidence-informed strategies may need deliberate adaptations to increase their compatibility to the state or community context in which they will be implemented.

[16] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

Please Note: If using GTO IPV/SV, Step 7 Process Evaluation will walk SVPP committees through a process of assessing if the actual implementation of a strategy matches how the SVPP committee intended that strategy to be implemented. This step should be implemented in Year 3 or 4 of the cooperative agreement.

Helpful Hint

GTO IPV/SV Step 4 provides guidance on how to balance fidelity and adaptation concerns related to evidence-based or evidence-Informed strategies.

To prepare for GTO IPV/SV Step 4, SVPP committees should identify and document the evidence associated with evidence-based and evidence-Informed strategies, including what the components of the evidence-based or evidence-informed strategy are so that these components can be assessed for how compatible they are to the context in which they will be implemented.

Tools and/or Resource

To aid in the documentation and/or assessment of evidence-based/informed and/or unproven strategies/programs, SVPP committees can use the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II and III** (**Appendix M**).

Adaptation to an Unproven Strategy

The best adaptations that can be made to an unproven strategy are those adaptations that increase the evidence supporting their use. The next section of this Step will define what evidence can be used to support the use of an unproven strategy and provides guidance on how to strengthen this evidence for an unproven Strategy.

Once the SVPP committee has strengthened the evidence supporting the use of an unproven strategy and documented what the evidence the unproven strategy is based on, then the SVPP committee can use the documentation to assess how compatible this evidence-adapted unproven strategy is to your state or community context in GTO IPV/SV Step 4.

Fidelity/ Adaptation Issues and Developing New Unproven Strategies

This guidance document or GTO IPV/SV is not intended to provide guidance on how to develop strategies from scratch. The development of strategies with a high likelihood of achieving positive outcomes requires resources and expertise that are beyond the ability of the guidance document or GTO IPV/SV.

Additionally, fidelity issues do not support the development of a new strategy by taking a few activities from one strategy (e.g., Expect Respect) and mixing it with a few activities from another strategy (e.g., Men of Strength Clubs). Instead the evidence supporting the use of these two unproven strategies

should be assessed and strengthened based on a strategy and compatibility assessment.

If the strategy and compatibility assessment indicates that additional activities are needed to strengthen the evidence supporting the use of either strategy, then the SVPP committee could consider integrating activities from one strategy to strengthen the evidence supporting the use of another strategy.

Evidence Supporting the Use of Unproven Strategies

As previously noted, most of the strategies currently used to prevent sexual violence are unproven strategies. Unproven strategies often reflect the ingenuity and expertise of practitioners who have worked to end sexual violence.

In addition, unproven strategies have a significant role in increasing the knowledge-base of how to prevent sexual violence when they are sufficiently documented and evaluated.

SVPP committees are encouraged to strengthen the potential ability of unproven strategies to prevent sexual violence by strengthening the evidence used to support their implementation. Strengthening the evidence used to support the implementation of an unproven strategy is beneficial because it:

1. ensures that the best of science and practice are being applied to the prevention of sexual violence; and,

2. increases the probability that state and/or community resources are being used in a manner most likely to prevent sexual violence.

What Evidence is Needed to Support the Use of Unproven Strategies?

The evidence supporting the implementation of unproven strategies derives mainly from the research literature regarding what has lead to successful behavior change and health promotion efforts in general and in specific areas such as HIV prevention, youth violence prevention, and substance abuse prevention.

Specifically, four types of evidence can be used to support the implementation of unproven strategies:

1. Documentation of how the unproven strategy has been informed by a behavior or social change theory that has been validated by research regarding the unproven strategy's included activities, structure (i.e., how these activities are linked together), and the content of the strategy (SAMHSA, 2007);[17]

[17] Citation identified in GTO IPV/SV as: Substance Abuse and Mental Health Services Administration (2007). Identifying and selecting evidence-based interventions: Guidance

2. Documentation of how the unproven strategy is similar in theory, activities, structure, and content to another strategy that is considered to be evidence-based or evidence-informed for sexual violence in particular or for other health issues, such as HIV prevention (SAMHSA, 2007);

3. Documentation of how the unproven strategy reflects Prevention Principles that research has shown lead to behavioral or social change (SAMHSA, 2007);

4. Documentation of how the unproven strategy includes sexual violence primary prevention content that emphasizes health promotion, rather than deterrence or risk reduction, approaches.

The four types of evidence used to support the implementation of unproven strategies will be discussed further detail below.

State-Level Considerations for Evidence Supporting Unproven Strategies

It may be hard to understand how state-level SVPP committees would utilize evidence supporting unproven strategies in their state level planning efforts as many of the state-level strategies may be policy changes.

For guidance on state level considerations for evidence supporting unproven strategies, please refer to the Implementation of GTO IPV/SV Steps 3-5 at a State Level section of the guidance document.

Helpful Hint

SVPP committees are encouraged to strengthen the evidence supporting the use of an unproven strategy by first adequately describing their unproven strategy in terms of a behavior or social change theory or documenting how the unproven strategy is similar in theory, activities, structure, or content, or structure to an evidence-based or evidence-informed strategy.

These **two types of evidence are prioritized over prevention principles and sexual violence primary prevention content** as they provide supporting evidence for how all the activities of a particular strategy fit together to lead to behavior change, which the prevention principles and the addition of sexual violence content are not able to do.

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document for the strategic prevention framework state incentive grant program. Washington, D.C.: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. Retrieved September 2007 from http://download.ncadi.samhsa.gov/csap/spfsig/Final_SPFGuidance_Jan04_2007.pdf

Please Note: If using GTO IPV/SV, Step 9 the continuous quality improvement process SVPP committees will have the opportunity to revisit how to strengthen the evidence supporting the use of their unproven strategies based on their program evaluation findings and the types of evidence. This step should be implemented in Year 3 or 4 of the cooperative agreement.

Helpful Hint

It is important for SVPP committees to understand how to document the evidence supporting the use of an unproven strategy so when the SVPP committees are assessing their capacities (GTO IPV/SV Step 5) to implement the unproven strategy they can develop policies, funding structures, training, technical assistance and monitoring mechanisms that could encourage the documentation of and continuously strengthen of the evidence supporting the use of unproven strategies throughout their state and/or community.

Documentation of how to use evidence to support the implementation of an unproven strategy

Introduction

This section will describe the four approaches on how to use evidence to support the implementation of an unproven strategy. These approaches are:

- documentation of how the unproven strategy has been informed by a behavioral or change theory;
- documentation of how the unproven strategy is **similar in theory, activities, structure, and content** to another strategy that is considered to be evidence-based or evidence-informed for sexual violence;
- incorporation of Prevention Principles into the unproven strategy; and,
- incorporation of sexual violence primary prevention content which emphasizes health promotion approaches into the unproven strategy.

Approach 1: Informed by a Behavioral or Change Theory

The **first approach** [18] to use evidence to support the implementation of unproven strategies is to document how the unproven strategy has been informed by a behavior or social change theory that has been validated by research regarding the unproven strategy's included activities, structure (i.e., how these activities are linked together), and the content of the strategy.

The ultimate goal in preventing sexual violence is to prevent the behaviors by individuals and changing community and societal norms that support and condone sexual harassment and sexual violence.

Prevention strategies should be based on theories that have been validated by research to lead to behavior change or social change for a variety of health topics. Theories provide guidance on how to affect the behavior of individuals by changing attitudes, knowledge, norms, practices, and policies at all levels of the social ecological model.

[18] As a reminder, information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual. As additional information becomes available, this section will be updated as needed.

SVPP committees can strengthen the evidence supporting the use of an unproven strategy by adapting its activities, structure and content to reflect a validated behavioral or social change theory.

In addition, using tested theories to develop prevention strategies can enhance the SVPP committee's decision-making by ensuring that decisions are not based on assumptions or perceptions about what might work, but on lessons learned from other fields regarding what works to promote behavior change and adoption.

Strategies supported by a well-validated behavior or social change theory are considered more likely to achieve their goals than strategies without theoretical support. The four theories commonly used in public health and heath promotion are:

1. Health Belief Model
2. Theory of Reasoned Action
3. Diffusion of Innovation
4. Transtheoretical Model

Information regarding the above theories can be viewed at http://www.comminit.com/changetheories.html and http://www.csupomona.edu/~jvgrizzell/best_practices/bctable.html

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Helpful Hint

If using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III** (**Appendix M**), this would be a great opportunity for the SVPP committee to document how a strategy is informed by a theory, what activities, are included in the strategy, the structure of the strategy, and the strategy's content.

Approach 2: Similar in Theory, Activities, Structure and Content

The **second approach** to use evidence to support the implementation of unproven strategies is to document how the unproven strategy is **similar in theory, activities, structure, and content** to another strategy that is considered to be evidence-based or evidence-informed for sexual violence in particular or for other health issues, such as HIV prevention, youth violence prevention, etc.

In addition, SVPP committees can strengthen the evidence supporting the use of an unproven strategy by ensuring that the strategy reflects the **theory, activities, structure, and content** of an evidence-based or evidence-informed for sexual violence in particular or for other health issues in general.

Helpful Hint

If using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III** (**Appendix M**), this would be a great opportunity for the SVPP committee to document how a strategy is informed by a theory, what activities, are included in the strategy, the structure of the strategy, and the strategy's content.

Approach 3: Incorporation of Prevention Principles

The **third approach** to use evidence to support the implementation of unproven strategies is to document how the unproven strategy reflects Prevention Principles that research has shown lead to behavioral.

According to the 2003 **Nation et. al article** (**Appendix A**); there are nine principles that can help prevention practitioners select, modify, or create more effective education programs.

There are three prevention principles in particular that SVPP committees could use to strengthen the evidence supporting the use of unproven strategies. These are:

- sufficient dosage/exposure;
- appropriately timed; and,
- active, skill-based teaching activities (varied teaching methods).

For additional information on prevention principles including definitions, please refer to the Prevention Concepts section of the guidance document as well as **Appendix A, the 2003 Nation et. al article**.

The principles generally focus on one aspect of a strategy. Specifically, sufficient dosage focuses on *how much* of a strategy should a person be exposed to, while appropriately timed focused on *when* a strategy should be available to a person, and active, skill-based teaching activities focuses on *how to promote* change in a population.

At first glance, it may appear that these three principles apply only to individual level strategies. However, **these principles can apply to relationship, community, and societal level strategies** when one considers that in planning any strategy, the issues of how much of the strategy should a population receive, when should the strategy be to made available to that population, and how the strategy should promote change within that population are critical issues that should be considered when planning for the needs of any population.

Sufficient Dosage/ Exposure

The amount of exposure needed is often directly related to the participants' degree of risk as assessed by the various risk factors across the social ecological model. Thus, the dosage needed to produce positive health outcomes with a selected population generally tends to be higher than the dosage needed to produce positive health outcomes with a universal population. Each strategy, whether for universal or selected populations, should have sufficient dosage. Effective strategies, on average, provide more contact with participants than ineffective strategies.

The dosage of any strategy needs to be carefully considered prior to the implementation of the strategy to ensure that the intended population will receive enough of the strategy to produce the desired outcomes.

Dosage is measured differently depending on which level of the social ecology a strategy is being implemented. Dosage for an individual level social/life skill strategy might be measured by session length (i.e., time needed per session to complete all the activities in that session), number of sessions, and duration (i.e., total time period to complete the strategy, such as a semester or summer).

Dosage for a community level social marketing campaign might be measured by newspaper tracking that reports the volume of coverage and how often the coverage accurately reflects the campaign's message[19]; by television tracking that reports what stations aired a PSA and the estimated audience size at the time and date the PSA was aired; by website monitoring that report number of hits to a website, navigation patterns, popular and unpopular content areas, who accessed the site, and how long they stayed.[20]

Appropriately Timed

Appropriately timed strategies focus on changing the developmental trajectory of sexual violence by reducing risk factors or increasing protective factors associated with sexual violence prior to a person perpetrating or experiencing sexual violence. Appropriately timed strategies also take the developmental (i.e., intellectual, cognitive, and social) needs of participants into consideration.

Specifically, appropriately timed prevention strategies encourage people to

[19] Citation from GTO IPV/SV is Radtke, J. M. (1998). Strategic communications for nonprofit organizations. New York: John Wiley & Sons.

[20] Citation form GTO IPV/SV is Coffman, J. (2002). Public communication campaign evaluation: An environmental scan of challenges, criticisms, practice and opportunities. Cambridge, MA: Harvard Family Research Project.

adopt healthy behaviors and to avoid beginning unhealthy ones. In this way, effective prevention strategies work to interrupt the development of the problem behavior in a manner that fits the developmental stage of the participants.

Active, Skill-based Teaching Activities (Varied Teaching Methods)

Using active, skill-based teaching activities reinforces key concepts while addressing individual learning styles. Strategies that only include activities focused on changing an individual's knowledge, attitudes and beliefs are usually not as effective as those strategies that also include activities focused on building skills.

Prevention strategies that include active, skill-based teaching activities recognize that behavior adoption and change is not a one time event, but a process that requires practice of new skills in order for these skills to become integrated into one's routine behaviors. Prevention strategies often include several skill-based teaching activities to promote behavior adoption.

As noted earlier, strategies are composed of several activities. Prevention strategies will often include activities that focus on knowledge change, attitude change and behavior change. In these cases, knowledge and attitude change activities will precede behavior change activities as the knowledge and attitude activities provide the rationale/motivation for why the behavior change is needed.

Table 4 provides an overview of commonly used activities[21] by type of individual change desired.

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[21] Citation from GTO IPV/SV is: National Institutes of Health, 2001

Table 4. Commonly Used Activities to Promote Individual Change

Type of Change	Activities Used to Support Change
Knowledge Activities: Present information	o Computer-assisted instruction o Discussion o Field trip or tours o Films, TV, tapes o Hand-outs o Lecture o Readings
Attitude Activities: Address attitudes or beliefs (e.g., women mean 'yes' when they say 'no' to sexual activity) that may hinder or support change	o Brainstorming o Case studies o Creative arts o Field trips o Open-ended discussions o Role playing o Panel presentations Some of the activities listed above in the knowledge activities box may also address attitudes and beliefs.
Behavior Activities: Promote practice and development of skills	o Action plans o Demonstrations o Guidance practice with feedback o Practicum o Role playing o Simulations

Helpful Hint

If using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III** (**Appendix M**), this would be a great opportunity for the SVPP committee to document how a strategy will incorporate the prevention principles.

Approach 4: Incorporation of Sexual Violence and Health Promotion Content

The **fourth approach** to use evidence to support the implementation of unproven strategies is to document how the unproven strategy includes sexual violence primary prevention content that emphasizes health promotion, **rather than** deterrence or risk reduction approaches.

Sexual Violence Prevention Content

As many unproven strategies used by SVPP committees will be borrowed from other fields, these strategies will lack the specific sexual violence primary prevention content needed to ensure that sexual violence risk factors/protective factors are appropriately addressed.

Sexual violence primary prevention content **should be** added to unproven strategies in the knowledge activities, attitude activities and behavior activities that define sexual violence, describe its occurrence, describe how it is preventable, increase motivation to see its elimination as well as to not perpetrate it and provide opportunities to practice skills that prevent sexual violence. **This content should be linked to the specific risk/protective factors of your universal or selected population**.

When adding sexual violence primary prevention content to an unproven strategy, some SVPP committees may consider adding some information to the strategy that might be considered secondary or tertiary prevention content, such as how to access victim services or how to report a sexual violence assault to authorities.

The addition of secondary and tertiary prevention content is appropriate and ethical as some in the population to receive the strategy have probably been victimized. **The important point is to keep the majority of the content focused on primary prevention, while making sure that anyone victimized has adequate access to any needed services.**

Health Promotion Content

The health promotion approach to the prevention of sexual violence emphasizes promoting the behavior or social conditions you want others to adopt rather than defining the behavior (see deterrence below) or social conditions you want to see eliminated. This content relies on the health promotion perspective that emphasizes the adoption of positive behaviors and social conditions, rather than solely the elimination of negative behaviors and social conditions associated with sexual violence.

For example, sexual violence health promotion primary prevention content emphasizes the promotion of strong, stable, and positive relationships between children and adults, among adolescents, and among adults.

Deterrence-based Content

Another perspective on prevention content is deterrence-based content that relies on fear of punishment to deter someone from perpetrating sexual violence. This fear of punishment can also change social norms that support the perpetration of sexual violence. However, deterrence-based content does not emphasize changing individual motivation related to perpetrating sexual violence so much as it emphasizes the negative consequences of getting caught for perpetrating sexual violence.

In addition, deterrence content does not provide information or skill building regarding healthy intimate partnerships or healthy, respectful sexuality. Deterrence content does not provide a person with the information regarding what to do, so much as deterrence content provides a person with information on what not to do. Health promotion content provides a person with information on what to do and skill building on how to do it.

Risk Reduction Content

A final perspective on prevention content is risk reduction content, also referred to as target hardening or opportunity reduction content that emphasizes actions that people can take to reduce their risk of being victims of sexual violence.

Risk reduction content **does not emphasize** changing individual motivation or social norms related to perpetrating sexual violence so much as they emphasize changing individual motivation or social norms related to perpetrating sexual violence against specific people or in specific situations.

Helpful Hint

If using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III** (**Appendix M**), this would be a great opportunity for the SVPP committee to document how to incorporate sexual violence primary prevention and health promotion content into a strategy.

Outcomes of GTO IPV/SV Step 3

Upon finishing GTO IPV/SV Step 3, the SVPP committee should have:

- multiple potential strategies in which to implement in the universal and selected populations;
- partially completed **Strategy Compatibility and Assessment Worksheet, Assessment Areas I, II and III (Appendix M)**; and,
- an understanding of the evidence supporting the multiple potential strategies that needs to be retained.

This is information that will be used in the implementation of the next section, GTO IPV/SV Step 4 – Community and State Context.

State and Community Context (GTO IPV/SV Step 4)[22]

Introduction

The next step in the GTO IPV/SV process is to determine how might the potential strategies identified in GTO IPV/SV Step 3 need to be adapted in order to be more compatible the state and community context.

This introduction provides an overview of GTO IPV/SV Step 4: State and Community Context, important terms used in this step, why this step is important, and a process check-in for SVPP committees.

Overview of GTO Step 4: State and Community Context

In GTO IPV/SV Step 1, the SVPP committee identified the risk and protective factors associated with your universal and selected populations. In GTO IPV/SV Step 2, the SVPP committee Team utilized the risk and protective factor information to develop preliminary goals and outcome statements for your universal and selected populations.

In GTO IPV/SV Step 3, the SVPP committee identified one or more potential strategies[23] that would meet the goals and outcome statements as well as address the risk and protective factors of your universal and selected populations. By now you should have:

- One or more potential strategies to assess against the state and community context, and
- Assessment Areas I, II, and III of the **Strategy Compatibility and Evidence Assessment Worksheet (Appendix M)** completed for your potential strategies

GTO IPV/SV Step 4 will assist the SVPP committee in:

- Assessing each potential strategy's state and community context, which refers to the setting context and the population specific contextual issues associated with your universal or selected populations

[22] Information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual. This is most recent information regarding the major concepts needed to implement the process.

[23] The term potential strategies is used intentionally as the SVPP committee needs to review the evidence supporting the use of the strategy (GTO IPV/SV Step 3), contextual issues associated with the strategy (GTO IPV/SV Step 4), and the capacity needed to support the implementation of the strategy (GTO IPV/SV Step5) prior to determining the ultimate strategy to be implemented.

- Determining if adaptations to the potential strategy's core components are needed based on the setting context and population specific contextual issues

- Balancing fidelity to the evidence supporting the use of the potential strategy as documented in GTO IPV/SV Step 3 and compatibility of the potential strategy to your state's or community's context when adaptations to the potential strategy are warranted

- Documenting any adaptations to the potential strategy to promote proper implementation, an accurate process evaluation, and the preservation of evidence supporting the use of the strategy.

Please Note: If using GTO IPV/SV documenting the adaptations is important information when the SVPP committee works through GTO IPV/SV Steps 7-9 (Process Evaluation, Outcome Evaluation, and Continuous Quality Improvement). These steps should be implemented in Year 3 or 4 of the cooperative agreement.

After this introduction, key sections of GTO IPV/SV Step 4 are presented as follows:

- Understanding state and community context, compatibility, and adaptation

- Understanding and assessing setting contextual issues

- Understanding and assessing population specific contextual issues

- Adapting your evidence-supported strategy

- Outcomes of this Step

- Before Moving on to GTO IPV/SV Step 5 Capacity Building

- Assessment Area IV: Assessing Compatibility and Capacity Issues (**Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)**

Helpful Hint

If using the draft **Strategy Compatibility and Evidence Assessment Worksheets (Appendix O), Assessment Area IV** would be a great opportunity for the SVPP committee to document contextual issues

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Important Terms	Here are some of the key terms[24] to become familiar with while reading this section.
Adaptation	The process through which strategies are modified deliberately or accidentally in one of four ways: (1) deletions or additions (enhancements) of strategy core components, (2) modifications in the nature of the components that are included, (3) changes in the manner or intensity of administration of strategy core components called for in the manual, curriculum, or core components analysis, or (4) cultural and other modifications required by local circumstances (SAMHSA, 2002)[25]
Capacity	Characteristics of individuals, organizations, or prevention systems that affect their ability to identify, address, and mobilize against sexual violence (Goodman et. al, 1998)[26]
Compatibility	The degree to which an evidence–based, evidence-informed, or unproven strategy is suited to the state and community context based on contextual assessment and the best judgment of the SVPP committee
Core Components	Those elements of a strategy that analysis shows are most likely to account for positive outcomes (SAMHSA, 2002)[27]

[24] If not identified, key terms developed and/or adapted by the CDC GTO IPV/SV Development Team in the development of the GTO IPV/SV. In addition, the information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual

[25] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

[26] Citation identified in GTO IPV/SV is: Goodman, Speers, Mcleroy, Fawcett, Kegler, Parker, Smith, Sterling and Wallerstein, 1998

[27] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

Readiness	Motivation and willingness of an individual, organization, or prevention system to develop and implement IPV/SV prevention programming (Goodman et. al, 1998)[28]
State or Community Context	The larger environment in which a strategy is immersed and implemented (US DHHS, 2005)[29]. GTO IPV/SV addresses two broad contextual areas: setting and population specific issues. Setting contextual issues include institutional and organizational characteristics, location, and political environment. Population specific contextual issues include ethnic/racial identity, religious identity, sexual orientation and gender identity, education, income, and social norms within the population. Each SVPP committee may identify other contextual issues more relevant to their particular circumstances and the potential strategy.
Fidelity	The actual strategy implementation matches how the strategy was intended to be implemented (US DHHS, 2005)[30] by: (1) the original developer of the strategy; and, (2) by the SVPP committee after any adaptations made by the SVPP committee
	Please Note: If using GTO IPV/SV, Step 4 deals with fidelity to the evidence supporting the use of a potential strategy as documented in GTO IPV/SV Step 3. GTO IPV/SV Step 7 deals with fidelity to strategies as they were intended to be implemented by a SVPP committee after completing

[28] Citation identified in GTO IPV/SV is: Goodman, Speers, Mcleroy, Fawcett, Kegler, Parker, Smith, Sterling and Wallerstein, 1998

[29] Citation identified in GTO IPV/SV is: US Department of Health and Human Services (HHS), Centers for Disease Control and Prevention: Office of the Director, Office of Strategy and Innovation (2005). *Introduction to program evaluation for public health programs: A self-study guide*. Atlanta, GA: Centers for Disease Control and Prevention.

[30] Citation identified in GTO IPV/SV is: US Department of Health and Human Services (HHS), Centers for Disease Control and Prevention: Office of the Director, Office of Strategy and Innovation (2005). *Introduction to program evaluation for public health programs: A self-study guide*. Atlanta, GA: Centers for Disease Control and Prevention.

GTO IPV/SV Steps 3-5. GTO IPV/SV Step 7 is intended to be implemented in Year 3 or 4 of the cooperative agreement.

Why this Step is Important?

Even the strongest evidence-based strategies can fail to produce their expected outcomes when implemented in contexts that are different from the one in which the strategy was proven to be effective (Ganju, 2003[31]; Schoenwald et. al 2001[32]; Hoagwood et. al, 2001[33]; Tortolero et. al, 2005[34]).

An inability to adapt strategies based on the unique contexts of this different At the same time, accidental adaptations to a strategy and lack of capacity to adequately implement a strategy can do more harm than good in certain contexts (SAMHSA, 2002)[35].

Accidental adaptations to a strategy make it difficult to know what 'version' of the strategy is to be implemented and therefore, if the version to be implemented will produce the desired results state or community can lead to the implementation of strategies that are irrelevant or inappropriate for certain settings and meeting the needs of a universal or selected population

[31] Citation identified in GTO IPV/SV is: Ganju, V. (2003). Implementation of evidenced-based praticess in state mental health systems: Implications for research and effectiveness studies. *Schizophrenia Bulletin,* 29(1), 1179-1189

[32] Citation identified in GTO IPV/SV is: Schoenwald, S.K., Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of Interventions: What Matters When? *Psychiatric Services* 52(9), 1190-97.

[33] Citation identified in GTO IPV/SV is: Hoagwood, K., Burns, B.J., Kiser, L. Ringeisen, H., Schoenwald, S.K. (2001). Evidenced based practice in child and adolescent mental health services. *Psychiatric Services* 52(9), 1179-1189.

[34] Citation identified in GTO IPV/SV is: Tortolero, Markham, Parcel, Peters, Escobar-Chaves, Basen-Engquist, 2005

[35] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

(SAMHSA, 2002)[36]. (US DHHS, 2005)[37].

Thus, SVPP committees need to understand the context in which a strategy will be implemented in order to make informed, deliberate adaptations to potential strategies when warranted and/or build needed readiness and capacities so that these strategies are well-documented, relevant, and appropriate and produce the desired outcomes.

GTO IPV/SV Step 4 will assist the SVPP committee in assessing how similar or dissimilar your state and community context is to other contexts in which your potential strategy has been implemented in order to determine if adaptations to the core components of the strategy are warranted so that the strategy has a good chance of producing the desired outcomes.

In some cases, this contextual assessment will indicate that readiness and capacity building issues need to be addressed prior to or at the same time as any adaptations to the strategy so that the strategy can produce the desired outcomes. Contextual readiness[38] assessments are addressed in this step (e.g., how ready an organization is to address IPV/SV prevention).

Please Note: If using GTO IPV/SV, how to build readiness and assess and build capacity are covered in more depth in GTO IPV/SV Step 5.

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[36] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

[37] Citation identified in GTO IPV/SV is: US Department of Health and Human Services (HHS), Centers for Disease Control and Prevention: Office of the Director, Office of Strategy and Innovation. (2005). *Introduction to program evaluation for public health programs: A self-study guide.* Atlanta, GA: Centers for Disease Control and Prevention.

[38] Some readiness assessments of the SVPP committee and the larger prevention system (optional) at the state or community level may have been conducted in GTO IPV/SV Step 1.

State and Community Contextual Issues

State and community contextual issues are assessed in two broad areas: the setting in which the strategy is to be implemented and population specific contextual issues related to the universal or selected populations or subgroups within these populations that would be served by the strategy (Castro et. al, 2004)[39].

In assessing setting contextual issues, SVPP committees will be able to identify such things as how characteristics of the implementing *institution or organization, location in which the strategy will be implemented and political environment* could affect implementation and what possible adaptations may be needed to increase the strategy's compatibility with its implementation context.

In assessing population specific contextual issues, SVPP committees will be able to identify such things as how the *characteristics, risk/protective factors to be addressed, values, norms and circumstances faced* by a particular universal or selected population are similar to or different from populations that have been previously served by a potential strategy.
A key aspect of this assessment process is the identification of strategy components that may not be suitable or may be potentially harmful to the universal or selected population. SVPP committees will also be able to identify what possible adaptations to the potential strategy may increase it's compatibility with a universal and/or selected population.

Understanding State and Community Context

Understanding the state and community context in which your potential strategy would be implemented can help determine:

1. whether or not and to what extent adaptation of a potential strategy is necessary in order to make the strategy compatible with the state or community context;

2. whether or not and to what extent readiness/capacity building issues need to be addressed prior to or at the same time as strategy adaptation;

3. whether the extent of adaptations needed would weaken the evidence supporting the use of the strategy as documented in GTO IPV/SV Step 3 to such an extent that it is uncertain as to whether or not the strategy would be able to produce the outcomes desired; and,

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[39] Citation identified in GTO IPV/SV is: Castro, F.G., Barrera, M., Martinez, C. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit *Prevention Science*, 5(1), 41-45.

4. which strategy of several potential strategies seems to balance fidelity to the evidence supporting the use of the strategy and compatibility to the context such that the strategy would be able to produce the outcomes desired.

Making deliberate adaptations to a strategy so that it is more compatible with your state and community context can have numerous benefits, such as:

- increasing the likelihood of strategy effectiveness (Castro et. al, 2004);[40]
- increasing the likelihood of community buy-in and engagement around sexual violence prevention in general and your strategy, specifically (Tuefel-Shone, 2006);[41]
- increasing the number of participants recruited or reached (Marek et. al, 2006);[42]
- increasing the likelihood of retaining larger percentage of participants for the duration of the strategy (Marek et. al, 2006[43]; Kumpfer et. al, 2002[44]), and

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[40] Citation identified in GTO IPV/SV is: Castro, F.G., Barrera, M., Martinez, C. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit *Prevention Science*, 5(1), 41-45.

[41] Citation identified in GTO IPV/SV is: Teufel-Shone, N. (2006). Promising strategies for obesity prevention and treatment within American Indian Communities. *Journal of Intercultural Nursing*, 17(3), 224-229

[42] Citation identified in GTO IPV/SV is: Marek, L., Brock, D.J., Sullivan, R. (2006). Cultural adaptations to a family life skills program: Implementation in rural Appalachia. *The Journal of Primary Prevention,* 27(2), 113-133.

[43] Citation identified in GTO IPV/SV is: Marek, L., Brock, D.J., Sullivan, R. (2006). Cultural adaptations to a family life skills program: Implementation in rural Appalachia. *The Journal of Primary Prevention,* 27(2), 113-133.

[44] Citation identified in GTO IPV/SV is: Kumpfer, K.; Alvardo, R., Smith, P., Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science* 3(3), 241-246.

- increasing the likelihood of sustaining strategy outcomes and ongoing implementation (Tuefel-Shone, 2006)[45].

Overall, GTO IPV/SV Steps 3-5 work together to ensure evidence, compatibility, and capacity are all considered when choosing a strategy to address the needs of your universal and selected populations. In GTO IPV/SV Step 4 an emphasis is placed on balancing the evidence supporting the use of a potential strategy with compatibility to the state or community context.

Too many adaptations to a strategy can weaken the evidence supporting the use of a strategy to such an extent that achieving the goals and outcomes desired is unlikely, while adhering to the evidence supporting the use of a strategy too stringently may lead to implementation failure due to poor compatibility with the state or community context. SVPP committees will need to use critical thinking skills and decide what balance is most appropriate for their circumstances.

Why This Step is Important for State Level Work?

This Step will help SVPP committees working at a *state level* to do any one or more of the following as appropriate for their states:

- Assess the compatibility of state wide strategies for both universal and selected populations,
- Promote strategy assessment and adaptation, when appropriate, to state wide strategies that are to be implemented in a local context,
- Pilot test and evaluate adapted strategies prior to wide-spread within-state dissemination,
- Guide local organizations through the process of balancing fidelity and contextual compatibility to state-wide strategies,
- Provide guidelines to local organizations regarding how to balance fidelity and contextual compatibility.

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[45] Citation identified in GTO IPV/SV is: Teufel-Shone, N. (2006). Promising strategies for obesity prevention and treatment within American Indian Communities. *Journal of Intercultural Nursing*, 17(3), 224-229

Important Principles for GTO IPV/SV Step 4

Process Check-in for SVPP Committees

There are several important principles that will significantly influence how this step is completed; these principles[46] in GTO IPV/SV are called Empowerment Evaluation[47] Principles.

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Before beginning this step, SVPP committee members should ideally have an in-depth appreciation of these seven principles and how they relate to your state and community context

Use of these principles can help your GTO Planning Team engage stakeholders representing setting contexts and universal or selected populations in a way that promotes community ownership and the implementation of strategies with the strongest supporting evidence. The relevant principles are:

- social justice;
- community knowledge;
- community ownership;
- inclusion;
- democratic participation;
- improvement; and,
- accountability

[46] There are 10 Empowerment Evaluation Principles, which are: 1) Improvement; 2) Community Ownership; 3) Inclusion: 4) Democratic Participation; 5) Social Justice; 6) Community Knowledge; 7) Evidence-based strategies; 8) Capacity Building; 9) Organizational Learning; and, 10) Accountability. The Principles are considered as a set of core beliefs that, as a whole, communicate the underlying values of empowerment evaluation and guide the work of empowerment evaluators. Fetterman, D. and Wandersman, A. (2005). Empowerment Evaluation: Principles in Practice

[47] Empowerment Evaluation is an evaluation approach that aims to increase the probability of achieving strategy success by: (a) providing stakeholders with tools for assessing the planning, implementation, and self-evaluation of their strategy, and (b) mainstreaming evaluation as part of the planning and management of the organization (Adapted from Fetterman, D. and Wandersman, A. (2007). Empowerment Evaluation: Yesterday, Today, and Tomorrow. *American Journal of Evaluation*, 28(2).

Detailed information about the principles and how the principles influences GTO IPV/SV Step 4 is below.

Social Justice

The empowerment evaluation principle of social justice refers to equity, fairness, and the absence of socially unjust risk and health differences (Levy et.al, 2006)[48]. Whether working with a universal or selected population, SVPP committees need to be aware of the diversity represented within each population and how social inequities in health and the social factors that influence health such as discrimination, persecution, prejudice, and intolerance are experienced by different members of a universal or selected population.

Part of being aware of the diversity represented within each population is also understanding that people belong to more than one identity category. For instance, a person is not just African-American, but is also a male or female. The experience of being a male African-American in a community may have much in common with the experience of being female in that some community, however, there may also be subtle or distinct differences that need to be understood prior to the implementation of a prevention strategy within the African-American population in that community so that the strategy is relevant and can achieve its desired outcomes.

One social factor that can be uniquely different across groups within a population is the way in which sexual violence is understood, explained, and experienced. GTO IPV/SV Step 4 emphasizes understanding these types of population specific contextual issues in order to ensure that potential strategies respect and take into consideration the diverse history, norms, and needs of various groups within a universal or selected population.

SVPP committees are encouraged to explore population specific contextual issues with members of the universal or selected population. By this point in the planning process, the SVPP committee should have developed processes and relationships that would facilitate successful communication. If necessary, a trained facilitator should be brought in to help you reach your goal of choosing and/or adapting a strategy that's compatible with the needs and norms of the universal and selected population, is appropriate for the contextual setting, and retains the evidence supporting the use of the strategy.

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[48] Citation identified in GTO IPV/SV is: Levy & Sidel, 2006

Community Knowledge

Community knowledge often represents the contextual issues that may affect how well a potential strategy works in a particular setting and for a specific population. Based on their lived experiences within a particular community, profession, or group, SVPP committees and other state or community stakeholders share this knowledge with each other and use it to assess how compatible a potential strategy is to a particular setting and with a specific population.

Thus, SVPP committees are encouraged to recruit and/or interact with other stakeholders when specific knowledge and insights related to particular settings or populations are not represented among SVPP committee members.

Community Ownership

Community ownership has been associated with sustainability of a program or strategy. This Step in the GTO process allows members of the SVPP committee and other stakeholders to invest in potential strategies by ensuring that the strategy is compatible with setting and population specific contextual issues.

The SVPP committee may want to consider what processes and actions it needs to take now to ensure that the strategy that is eventually implemented has adequate support and ownership by key stakeholders and groups. Every effort should be made to engage the stakeholders and groups you intend to work with now, so that there will be a sense of community ownership.

Inclusion

In this Step and according to this principle, SVPP committees would make a concerted effort to include people and organizations who are knowledgeable about the particular settings in which a potential strategy may be implemented and the needs and norms the universal or selected population or subgroups within these populations.

The knowledge and expertise of these people and organizations are vital to identifying potential areas of incompatibility between a strategy and the setting or population and ways to address this incompatibility (i.e., adapting the strategy and/or building capacity). By including these people and organizations you will also be fostering community ownership of the strategy to be implemented.

Democratic Participation

When engaging multiple stakeholders from varied backgrounds it is essential to have democratic processes in place so that everyone feels heard, appreciated, and respected. However, democratic participation doesn't always mean democratic decision making or the 'majority rules.'

The SVPP committee is responsible for taking into consideration all data that

is collected and making an informed decision about what strategy is chosen, how it needs to be adapted and what capacities will be needed prior to implementation. Communicating to key audiences how and why the SVPP committee ultimately made a decision can reinforce and support community ownership of the decision and communicate how community knowledge was or was not included in the decision making process.

Improvement

This principle assumes that SVPP committees desire to reduce the level of IPV and/or SV in their states and/or communities by working to improve their primary prevention strategies and their entire primary prevention system. GTO IPV/SV Step 4's key emphasis is on improving a strategy's compatibility with the state or community context so that it has a good chance of achieving its goals and outcomes.

In preparing for this step, the SVPP committee may want to have a conversation on how they view and value compatibility assessments and adaptations to a strategy. Specific questions to discuss are:

- what is compatibility;
- when is it important,;
- what does adaptation mean and how does adaptation affect the evidence supporting the use of the strategy; and
- have they adapted a strategy before, how have they adapted a strategy, and what were the results of any adaptations?

Accountability

Each member of the SVPP committee should be engaged in this process and hold each other accountable for gathering the needed expertise and information. Ultimately, the SVPP committee will be accountable for the strategy that is chosen and whatever adaptations that are made.

Therefore, documenting the process for ensuring fidelity to the evidence supporting the use of the strategy, assessing contextual compatibility, and deciding which adaptations, if any, are needed an essential part of this step.

Helpful Hint

The **Strategy Compatibility and Assessment Worksheets (Appendix M)** that began in GTO IPV/SV Step 3 and will continue throughout GTO IPV/SV Steps 4 and GTO IPV/SV 5 can help the SVPP committee with this documentation. Specifically, **Assessment Area IV** in the **Strategy Compatibility and Assessment Worksheet (Appendix O)**.

Understanding State and Community Context, Compatibility, and Adaptation

This section provides an overview of state and community context, compatibility, and adaptation. For additional information about adaptation, see **Appendix P for Bell et. al article** on ***Challenges in Interventions*.**

Overview

State and community context is defined as the larger environment in which a strategy is immersed and/or implemented (US DHHS 2005)[49]. The context in which the SVPP committee plans to implement the potential strategies from GTO IPV/SV Step 3 may or may not be similar to previous contexts in which these strategies have been implemented.

Dissimilarity in contexts may indicate that a strategy is not compatible with the particular state or community context or may need to be adapted to make it compatible or that some readiness/capacity building needs to occur prior to a strategy being implemented. Compatibility[50] is the degree to which a strategy is suited to the current state and community context based on a contextual assessment and the best judgment of the SVPP committee.

Please Note: Readiness and capacity building are covered only briefly in GTO IPV/SV Step 4 and more in-depth in GTO IPV/SV Step 5.

Balance between Contextual Compatibility and Fidelity

In this step, contextual compatibility is balanced with fidelity to the evidence supporting the use of the potential strategy as documented in GTO IPV/SV Step 3. Assessment and adaptation, if needed, are the processes through which this balance is achieved.

For some SVPP committees, contextual assessment and strategy adaptation may take place concurrently. For other SVPP committees, the contextual assessment process may come first, followed by strategy adaptation process. Each SVPP committee will need to decide for themselves

[49] Citation identified in GTO IPV/SV is: US Department of Health and Human Services (HHS), Centers for Disease Control and Prevention: Office of the Director, Office of Strategy and Innovation (2005). *Introduction to program evaluation for public health programs: A self-study guide.* Atlanta, GA: Centers for Disease Control and Prevention.

[50] Compatibility is used in this step rather than the term 'fit' due to fit implying that there is one right, ideal, or correct answer. Compatibility is a matter of degree. GTO IPV/SV Step 4 assists SVPP committees in making an informed judgment regarding how compatible a strategy is to the state and community context, what adaptations may be needed to make it more compatible, and/or what readiness/capacity issues need to be addressed prior to strategy implementation.

appropriate assessment and adaptation process.

As a result of the contextual assessment process, the SVPP committee may reach one or more of these conclusions:

1. The potential strategy is compatible enough with our state or community context that it does not need to be adapted from the way its core components were documented in GTO IPV/SV Step 3. That is, the conclusion is that the strategy can be implemented 'as is' and have a realistic chance of achieving the desired outcomes. An example of this is a SVPP committee deciding after their contextual assessment to implement MOST Clubs as originally defined by Men Can Stop Rape.

2. The potential strategy has some core components that are not compatible enough with our state or community context. That is, the conclusion is that the strategy requires some adaptations to make it compatible with the state or community context in order for it to have a realistic chance of achieving the desired outcomes. When adaptations are warranted is discussed in-depth below.

3. The potential strategy is so completely incompatible with our state or community context that has no realistic chance of achieving its desired outcomes and should not be implemented. The SVPP committee should examine other potential strategies.

4. The potential strategy is incompatible to some extent but that readiness and capacity building, rather than adaptations to the strategy is the best course of action if the strategy is to have a realistic chance of achieving its desired outcomes.

When is Strategy Adaptation Warranted?

Strategy adaptation is warranted when:

- the strategy is so incompatible with the one or more of the contextual areas that implementing it may actually be detrimental to the universal or selected population.

- there are components of the strategy that are amenable to adaptation without significantly affecting the evidence supporting the use of the strategy.

- the best possible strategy needs adaptation in order to be compatible with the strategy's implementation setting,

- readiness and capacity building activities *alone* will not make the strategy compatible with the state or community context.

Adaptations to a strategy can occur at any time during the planning and implementation process. Adaptation is the process through which strategies are modified deliberately or accidentally in one of four ways:

(1) deletions or additions (enhancements) of strategy core components,

(2) modifications in the nature of the components that are included,

(3) changes in the manner or intensity of administration of strategy core components called for in the manual, curriculum, or core components analysis, or

(4) cultural and other modifications required by local circumstances (SAMHSA, 2002)[51]

Two Levels of Strategy Adaptations

Strategy adaptations are often considered as occurring on two levels: surface and deep.

- *Surface Structure* adaptations involve matching strategy materials and messages to observable, "superficial" characteristics of a universal or selected population or subgroups of these populations or the setting context in which your strategy is implemented.

  Surface adaptations may involve using people, places, language, product brands, music, food, locations, and clothing familiar to, and preferred by, members of the universal or selected population (Resnicow et. al, 2000)[52]. The benefits of surface adaptations are that they can increase buy-in, community engagement, recruitment and receptivity of a strategy.

- *Deep Structure* adaptations involve incorporating the cultural, social, historical, environmental, and psychological forces that influence the incidence of sexual violence in the universal or selected population or the setting context of your strategy.

  The benefits of deep adaptations are that they increase retention of participants, the attainment of strategy outcomes, sustainability of strategy outcomes, and address the social determinants of health

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[51] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

[52] Citation identified in GTO IPV/SV is: Resnicow, K., Soler, R., Braithwaite, R., Ahluwalia, J., Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology,* 28(3), 271-290.

that exacerbate health disparities (Resnicow et. al, 2000)[53].

Both surface and deep structure adaptations are an important part in the success and sustainability of strategies. These adaptations have to be balanced with fidelity to the evidence supporting the use of a strategy.

Helpful Hint

In the adaptation of prevention focused education materials, media campaigns or curricula it is recommended that such materials are based on the best available evidence and input from representatives of the community for whom the materials are developed.

Community representatives via community mobilization and/or coalition building efforts should be active participants in the adaptation, development, production, implementation, and evaluation processes to ensure state and community context. SVPP committees should use CDCYNERGY Violence Prevention Edition, Your Guide to Effective Health Communication as a planning tool when developing and/or adapting media campaigns.

In summary, this step walks SVPP committees through the process of assessing **IF** adaptations are needed and if so, **WHAT** adaptations are needed - surface or deep.

This step is important even if the no deliberate adaptations are made to a particular strategy in order to ensure that there are no contextual issues that would affect how the strategy is implemented and its ability to produce the desires outcomes. This step also assists in developing an implementation plan for the strategy as various implementation issues are addressed through the contextual assessment process.

Please Note: If using GTO IPV/SV, this Step addresses deliberate adaptations made to a strategy to make it more compatible with the state and community context. GTO IPV/SV Step 7, process evaluation, will assess for any accidental modifications made during the implementation process. GTO IPV/SV Step 7 is intended to be implemented in Year 3 or 4 of the cooperative agreement.

Please Note: For those already implementing: Don't assume you need to skip this step if you are already implementing a strategy! Going through GTO IPV/SV Steps 3-5 as a part of your process evaluation in GTO IPV/SV

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[53] Citation identified in GTO IPV/SV is: Resnicow, K., Soler, R., Braithwaite, R., Ahluwalia, J., Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology,* 28(3), 271-290.

Step 7 can help the SVPP committee identify a need for adaptations for strategy improvement. GTO IPV/SV Step 7 is intended to be implemented in Year 3 or 4 of the cooperative agreement.

State and Community Context Areas

For the purposes of GTO IPV/SV, state and community context is broken down into two broad areas: setting context and population specific contextual issues.

Although discussed separately here, these two broad areas overlap and influence each other. SVPP committees will need to decide how to balance competing compatibility issues within and across these two broad areas and with the evidence the evidence supporting the use of the potential strategy as documented in GTO IPV/SV Step 3.

State and Community Contextual Areas

Specific setting contextual issues to be discussed are:

- o institutional/organizational characteristics;
- o political environment; and,
- o location.

Population specific contextual issues to be discussed are:

- o racial/ethnic identity;
- o religious identity;
- o sexual orientation and gender identity;
- o education level;
- o income level; and,
- o social norms.

SVPP committees may identify other contextual issues that need to be addressed.

For each specific contextual area (e.g., institutional/organizational characteristics), this section will provide:

- o a definition of the contextual area;
- o guidance on data/information needed to assess that area;

- considerations regarding how each contextual area can affect the implementation of a strategy and sexual violence prevention in general; and,

- an example of how the contextual area affected the implementation of a strategy.

This information will provide SVPP committees with a starting point for their contextual assessments, but should not limit their assessment of each area.

Please Note: If using GTO IPV/SV, the process and outcome evaluation and CQI process (GTO IPV/SC Steps 7-9) will provide additional opportunities to identify and address contextual issues that may affect the implementation of your strategy. These steps should be implemented in Year 3 or 4 of the cooperative agreement.

Helpful Hint

May need to go back to GTO IPV/SV Step 1 and review/update the state profile as it should document some of the state and community context areas.

Helpful Hint

When assessing contextual issues for the potential strategy, the SVPP committee should assess the capacities for strategy implementation at the same time.

Tools and/or Resources

To aid in the documentation and/or assessment of state and community context areas, SVPP committees can use the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)**.

What to Focus on When Assessing Contextual Areas?

When assessing contextual areas, it is important that the focus of the review is on each area:

a. how sexual violence operates in the universal or selected population or subgroups within these populations;

b. how setting contextual issues and population specific contextual issues influence the promotion or prevention of sexual prevention; and

c. how the potential strategy selected can be hindered, harmful, or more effective within the setting context or with the universal or selected population.

Working at the State Level

As noted earlier, this Step will help SVPP committees working at a *state level* to do any one or more of the following as appropriate for their states:

- Assess the compatibility of state wide strategies for both universal and selected populations.
- Promote strategy assessment and adaptation, when appropriate, to state wide strategies that are to be implemented in a local context
- Pilot test and evaluate adapted strategies prior to wide-spread dissemination
- Guide local organizations through the process of balancing fidelity and compatibility to state-wide strategies
- Provide guidelines to local organizations regarding how to balance fidelity to a strategy's supporting evidence and compatibility to the context in with the strategy will be implemented.

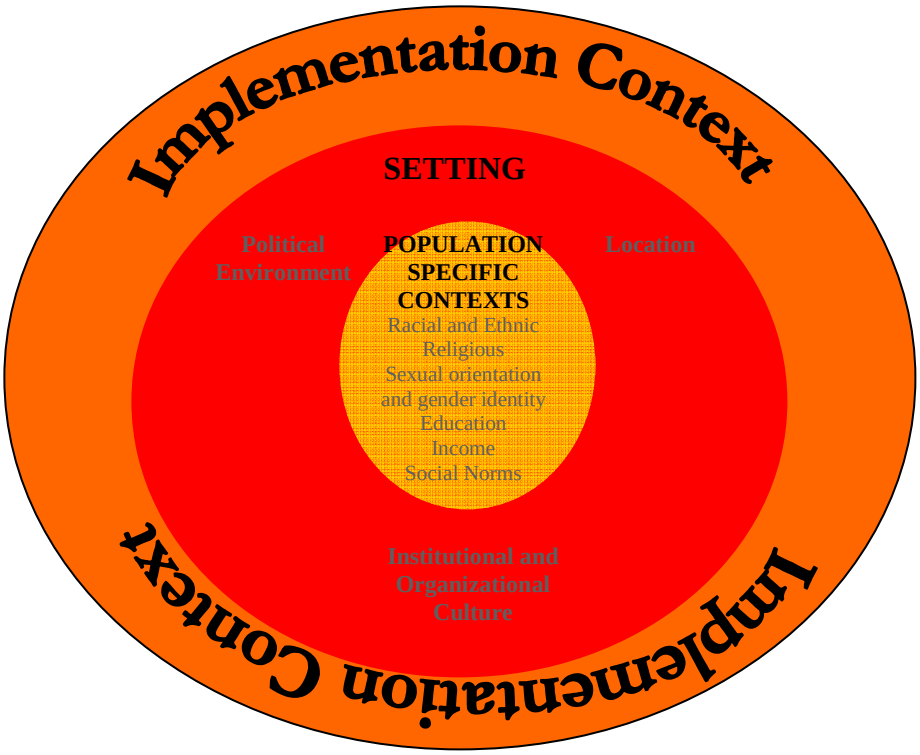
If pilot testing and evaluating an adapted strategy, this assessment may focus on whether surface or deep structure adaptations were most appropriate.

State and Community Context Figure

As noted earlier, state and community context is broken down into two broad areas: setting and population specific contextual issues. **Figure 6** below is intended to show how these two broad areas and specific contextual issues within these two broad areas overlap and influence each other.

The setting context includes the institution/organization implementing the strategy, the location where the strategy will be implemented and the political environment in which the strategy will be implemented. Population specific contextual issues are often individually defined, unique in every community, and play a major role in shaping the content of the strategy.

Figure 6 **Figure 6: Overlap of State and Community Context**



Understanding and Assessing Setting Contextual Areas[54]

Overview

Setting contextual areas affect how a potential strategy is implemented and include:

- o institutional and organizational characteristics,
- o location characteristics, and
- o the political environment

The settings for strategies across the social ecological model can vary tremendously. A setting for an individual level strategy may or may not be the same as the setting for a community level strategy.

For some strategies, SVPP committees will need to assess organizational characteristics, location characteristics, and political environment. For other strategies, SVPP committees will only need to assess organizational issues. At a minimum, that implementing organization's context should always be assessed.

Institutional and Organizational Characteristics

Definition

The language, customs, regulations, structures, processes, resources, and willingness/priorities that define the culture of an institution or organization.

Data and Information Needed

For sexual violence primary prevention, it is possible for one organization to implement a strategy within another organization. For instance, a local rape crisis center may implement a strategy within a middle school. The organizational characteristics of both the local rape crisis center (i.e., the implementing organization) and the middle school (i.e., implementation site) would need to be assessed in regard to how these characteristics would affect the implementation of the strategy. Assessment Area IV **(Strategy Compatibility and Assessment Worksheet (Appendix O)** provides space to assess both the implementing organization's and the implementing site's characteristics.

[54] As a reminder, information for this section is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual. This is most recent information regarding the major concepts needed to implement the process. The following sections will be updated and revised as the completed steps become available.

The SVPP committee will need to identify or designate which organization(s) will be implementing and/or involved in the implementation of the potential strategy either as the implementing organization, implementation site, or both.

After determining which organizations, it is then necessary to assess how ready each organization is to address sexual violence prevention in general and how compatible the organization's characteristics are to what is required to adequately implement the potential strategy.

This assessment will require engagement and dialogue not only with the leadership of the organization, but staff members who might implement the strategy, key stakeholders, current and former clients, and community members as well as review of any written materials such as mission statements, strategic plans, grants, curriculum, etc. Remember the principles of community knowledge, community ownership, inclusion and democratic processes during this assessment process.

An organization that will be implementing its first sexual violence prevention strategy will need time to understand the strategy, how compatible the strategy is with the organization's culture, and whether the organization has the capacity to implement the strategy. The SVPP committee is encouraged to develop a process that builds organizational readiness and capacity to adopt sexual violence prevention in general and a specific strategy.

When working with key organizational stakeholders, it is important to specifically address the following topics in a manner that promotes social justice, community knowledge, community ownership, inclusion, and democratic participation so that staff members can engage in constructive, forthright discussions regarding their organization's readiness and capacity to address sexual violence prevention in general and adopt a specific sexual violence prevention strategy:

1. what the core components of the potential strategy are and how they work;

2. what the potential outcomes of the potential strategies are;

3. what the financial and human resources necessary to support the strategy's implementation are; and,

4. how the integration of the strategy into the organization's work might affect other work done within the organization and what concerns/fears staff members may have regarding the integration of potential strategies into their organization's work.

Example to be Inserted

Multiple rape crisis centers within one state implementing the same strategy utilizing their RPE funds.

General Readiness Assessment

Readiness refers to an organization's willingness to make the primary prevention of sexual violence is a priority. This readiness refers to the larger organizational environment within which the strategy would be implemented.

Implementing a sexual violence primary prevention strategy within an organization that is not ready to address sexual violence prevention can affect the strategy's ability to produce the desired outcomes. Questions to assess how ready an organization is to address sexual violence prevention include:

- How might characteristics of this organization affect the promotion or prevention of sexual violence? For example, if the strategy is to be implemented in a school, do they have any policies against violence, bullying, and harassment that would indicate they are ready to address the issue of dating violence and sexual violence with their students?
- How does this organization understand sexual violence as an issue (e.g., just a criminal justice issue, just a woman's issue, just a private issue, from a victim-blaming perspective)?
- Are there competing issues within the community or organization that are of greater priority to the organization than the primary prevention of sexual violence (e.g. lack of victim services, meeting educational standards, or rebuilding after a natural disaster)? Will these competing issues negatively affect the implementation of a sexual violence prevention strategy or can synergies be created?
- Are there substantial changes to the organization's characteristics that are needed before the implementation of any sexual violence primary prevention strategy (i.e., does readiness have to be built prior to the implementation of a specific sexual violence strategy)? Are these changes feasible within a reasonable time period?

Strategy Specific Assessment

If an organization is ready in terms of willingness to address sexual violence, the next important step is to assess the compatibility between the organization's characteristics and the core components of the potential strategy by having members of the organization and representatives of SVPP committee discuss and identify:

- The degree to which the goals/outcomes, activities, structure and

content of this potential strategy are compatible with the organization's goals/outcomes, activities, structures and priorities? (See **Assessment Area IV** in the **Strategy Compatibility and Assessment Worksheet (Appendix O)**; and,

- How does this organization's characteristics compare to the characteristics of other organizations that have implemented this strategy? (See **Assessment Worksheet Area I** in the **Strategy Compatibility and Assessment Worksheet (Appendix M).**

Considerations

Based on the assessment, the SVPP committee GTO Planning Team can explore:

1. implementing the strategy 'as is' with no adaptations;
2. increasing the organization's readiness to prevent sexual violence ;
3. adapting the strategy's core components in such a way that the strategy still retains as much of the evidence supporting its use with the universal or selected population as possible;
4. modifying those characteristics of the organization that can easily be changed to support the implementation of this strategy as documented in GTO IPV/SV Step 3;
5. building the capacity of the organization to implement the strategy as documented in Step 3 and promote sexual violence prevention; and/or,
6. examining other potential strategies for compatibility with the state or community context due to this particular potential strategy being so incompatible with the state and community context that to make it compatible would significantly affect the evidence supporting its use.

Adopting the strategy 'as is' may appear to be a quick option toward implementation, but if the strategy is incompatible with the context, then it is unlikely that the strategy will achieve its desired outcomes. Thus, valuable resources would have been poorly used.

Strategy adaptation may also appear to be a quick option toward implementation, but if done without regard to the evidence supporting the use of the strategy, adaptation can also lead to the implementation of a strategy that is highly unlikely to lead to the desired outcomes.

Sometimes a quicker option may be to address the characteristics of an organization that can be easily modified to support the implementation of the

strategy. An example of such a modification might be to extend hours of operation one night per week to allow training of opinion leaders for an opinion leader strategy.

Increasing an organization's readiness to address sexual violence prevention in general and building the capacity of the organization to implement a specific strategy are often long-term endeavors. An organization may be able to implement a specific sexual violence prevention strategy without the entire organization being ready to address sexual violence prevention in general.

The key element found across the literature regarding organizational influences on strategies producing the desired outcomes is that the staff who are to implement the strategy must be well-trained. Training is considered to be a capacity building issue that will be covered in detail in GTO IPV/SV Step 5.

Example

To be developed and inserted

Location Characteristics

Definition

A geographic region as defined by county lines, census track, voting districts, city zones, or any other geographic neighborhood identifiers.[55]

Within a location, the universal or selected population may represent diverse racial and ethnic groups, have different religious preferences, and income levels, etc.

Assessment of a location should be complemented by an assessment of population specific contextual issues, which are addressed later in this GTO IPV/SV Step 4. Assessing the geographic location may be more pertinent to community and societal level strategies than to individual or relationship level strategies.

Data and Information Needed

The goals and outcomes statements developed for the universal and selected populations in GTO IPV/SV Step 2 should provide some type of guidance on what locations might be considered for implementation of a potential strategy.

For example, if the SVPP committee had the goal of reducing social norms supportive of sexual violence on college campuses, then one or several

[55] Definition developed by the CDC GTO IPV/SV Development Team

college campuses would be the location(s) for strategy implementation. As resources for sexual violence are not limitless, SVPP committees, especially state teams need to carefully assess what locations offer the best potential to reach their universal and selected populations.

After defining the location in which the strategy will be implemented, it is then necessary to answer the following questions regarding the location context:

- How does this location compare to any locations in which this strategy has been implemented by others, including the originator of the strategy?
- What are the unique characteristics of the specific location in which this strategy will be implemented that may affect the core components of this strategy? Unique characteristics include the demographic composition of the location (see population specific contextual issues for more information) educational opportunities, access to mass transportation, and the unique sexual violence related risk and protective factors.
- How would these unique characteristics affect the core components of this strategy?

Considerations

SVPP committees may want to consider the following critical questions as when assessing the compatibility between the potential strategy and the identified location:

- Based on the assessment, is this location the most appropriate location in which to implement this strategy?
- Do people define themselves by the current location standards or some other historical, political, ethnic, or racial standard that would make grouping them together difficult?
- Does the implementing organization already have established relationships within this location that would increase access, facilitate conversations, and stimulate change?
- Is the location ready to implement the strategy or does capacity need to be built?

Example

A small rural community in Wyoming would like to implement a social norms media campaign regarding male responsibility to prevent sexual violence. They have examined such a campaign that was implemented in Atlanta, GA

using mass media on radios, cable TV, mass transit, the internet, and school publications. As this rural community does not have mass transit or its own radio or cable TV outlets, it has decided to distribute the content of the social norms media campaign on the internet, in school publications, and by having posters mounted prominently in businesses that hire adolescent males and serve the adolescent population.

Prior to implementing the same social norms media campaign, the small rural community in Wyoming would assess similarities and differences between the populations served by the media strategy in Atlanta and the population to be served by this media campaign in this small rural Wyoming community.

These differences may or may not indicate that adaptations to the content of the media campaign are appropriate. Population specific contextual issues that might indicate that adaptations to a strategy's content are appropriate and addressed later in this step.

Political Environment

Definition

Differences or similarities between the history or current climate of laws, political representation, competing interest of involved parties and/or services among groups in a particular area.[56]

Data and Information Needed

Gather information that will help the SVPP committee assess how aspects of the current political environment may affect the core components of any potential strategies. Specific areas to assess are:

1. Priorities and interests of current state and local officials and representatives,

2. Competing interests among current stakeholders and potential stakeholders, and

3. Current laws, appropriations, and policies

Considerations

Often there is conflict as to whose responsibility it is to address sexual violence and to receive funding for prevention efforts. Take the political environment and other contextual issues into consideration together when devising an implementation plan for the chosen strategy.

[56] Definition developed by the CDC GTO IPV/SV Development Team

Example To be developed.

Understanding and Assessing Population Specific Contextual Issues

Overview

Population specific contextual issues refer to one's sense of belonging to a group and the part of one's thinking, perceptions, feelings, and behavior due to group membership. Each universal and selected population has a unique population context based on the groups that make up that population. For example, your universal population maybe all boys aged 12-18 that attend public schools. Within this population in your state there is a unique mix of ages, races/ethnicities, sexual orientation and gender identities, and religious identities.

Below are the six main categories of population contexts that the SVPP committee may examine to determine the compatibility of the strategy:

- Racial and Ethnic Identity
- Religious Identity
- Sexual Orientation and Gender Identity
- Income
- Education
- Social Norms

The SVPP committee may identity other population specific contextual issues that are not addressed in this step or in this adapted version of GTO IPV/SV.

It is important to note that often within some of these population contexts, such as racial and ethic identity, there is a group against which other groups are often compared or contrasted. For example, in the United States, Christianity is the most common religious identity and other religions are often compared and contrasted to Christian beliefs and norms.

The SVPP committee should have a good understanding of how racial/ethic identity, religious identity, sexual orientation and gender identity, education level, income level, and social norms influence the cultural values, beliefs and desired outcomes of a universal or selected population or subgroups within these populations. This understanding can help identify incompatibilities between a potential strategy and a specific population context and suggest possible adaptations needed.

When is Adaptation Warranted for Population Specific Contextual Issues?

As each universal and selected population can be diverse, SVPP committee may strive for strategy content that is considered 'multicultural' in that the content incorporates and appreciates perspective of multiple groups without assumptions of superiority or inferiority of one group or another (Resnicow et., 1999)[57]. Focusing exclusively on between group differences without appreciating between group similarities can result in strategies that do not achieve the desired outcomes (Resnicow et. al, 1999)[58].

Adaptations based on population specific contextual issues are warranted when:

1. Assessments reveal important variability across groups in either contextual processes influencing vulnerability to and protection from sexual violence;

2. Assessments reveal variability in response to potential strategies for the universal or selected population or subgroups within these populations; and,

3. Assessment indicates that the sexual violence arises within a distinct set of risk and protective factors in a given community.

Both surface and deep structural adaptations may be appropriate.

How to assess and adapt potential strategies requires participation from members of the universal and selected populations or subgroups within these populations (Reese et. al, 2007)[59]. Community ownership of the strategy by representatives of the universal or selected population is paramount. Thus, SVPP committees are encouraged to:

1. Develop positive working relationships with representatives from the universal or selected populations. Specific opportunities may include participation on planning committees and exploratory focus groups that entail exploring the thoughts, feelings, experiences, assumptions, etc. regarding sexual violence perpetration and

[57] Citation identified in GTO IPV/SV is: Resnicow, K., Baranowski, T., Ahluwalia, J., Braithwaite, R.L. (1999) Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease,* 9(1), 10-21.

[58] Citation identified in GTO IPV/SV is: Resnicow, K., Baranowski, T., Ahluwalia, J., Braithwaite, R.L. (1999) Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease,* 9(1), 10-21.

[59] Citation identified in GTO IPV/SV is: Reese & Vera, 2007

victimization, as well as, unique environmental risk and protective factors.

2. Develop and implement strategies that are valued by the members of the universal or selected population.

Whether through planning groups, exploratory focus groups or other interactive opportunities, representatives of the universal and selected population should be provided opportunities to provide feedback (SAMHSA, 2002)[60] on:

1. the core components of potential strategies,;
2. the potential outcomes of potential strategies;
3. the financial and human resources necessary to support the strategy's implementation; and;
4. the factors that would facilitate or limit members of the universal or selected population from participating in the potential strategy or developing community ownership of the strategy.

Helpful Hint

When working with representatives from your universal or selected population or subgroups within that population, it is important to explore how the following from various potential strategies would act as facilitators or barriers to participation by/reach/relevance with the universal or selected population:

1. Delivery structure and core components
2. Content
3. Location
4. Implementing organization

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[60] Citation identified in GTO IPV/SV is: Substance Abuse and Mental Health Services Administration. (2002). Finding the Balance: Program fidelity and adaptation in substance abuse prevention. A state-of-the-art review and executive summary.

Helpful Hint Related to Data and Information Needed

National and state data sets may not reflect the nuances in the way that people classify themselves (i.e., broad categories such as Hispanic as compared to specific cultural classification such as Mexican, Peruvian, or Dominican, etc.).

Therefore, for each population specific contextual issue that you examine, you should deeply consider the following data and information needs within each category. **Assessment Area IV** on the **Strategy Compatibility and Evidence Assessment Worksheet (Appendix O)** can help record and organize this information. In order for this data to be comprehensive and accurate, it should come from multiple sources that have been cross referenced.

Helpful Hint Related to Considerations

Depending on the strategy chosen, the SVPP committee will have to consider differences and similarities between population specific contexts as well as differences and similarities within a population context. For example, a faith based initiative that brings together Christian, Jewish, and Muslim faiths will have to consider adapting messages that are relevant and cohesive to all three faiths as compared to a faith based initiative that focuses on one Christian church or denomination.

Be aware that there may be a very diverse mix of risk and protective factors, cultures, and other identities collapsed into one general category of a racial and ethnic group, and the more these within group differences are taken into consideration when planning a strategy, the more appealing and potentially effective the strategy will be.

Racial and Ethnic Identity

Definition

Refers to one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behavior due to ethnic group membership. The ethic groups tends to be one in which the individual claims heritage and is very community and individually defined. Race and ethnicity is not an imposed label of belonging.

For surveillance purposes, the CDC's Office of Minority Health and Disparities and the U.S. Census Bureau have named 5 federally recognized racial and ethnic categories. They are American Indian and Alaskan Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander.

Data and Information Needed	For each universal or selected population, the SVPP committee will need to broaden their understanding of the: general level of acculturation; relocation and/ or migration history; trauma, loss, or possible PTSD; language preferences and impediments; magnitude and type of stressors specific to the particular identity; assets, risks, and protective factors; and unique prevention avenues (Kumpfer et. al, 2002[61]; Resnicow et. al, 1999[62]; Turner, 2002[63]). In addition, the SVPP committee will want to know how the problem is perceived within particular groups, and how the strategy will operate within particular population specific contexts.
Considerations	There may be fewer differences between two different ethnic and racial groups than there are within a particular racial or ethnic group (Resnicow, 2000).[64]
Example	To be developed.

Religious Identity

Definition	An individual's deeply held religious beliefs or association with a religious denomination, faith institution, religious leadership, or religious teachings.[65]

[61] Citation identified in GTO IPV/SV is: Kumpfer, K.; Alvardo, R., Smith, P., Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science* 3(3), 241-246.

[62] Citation identified in GTO IPV/SV is: Resnicow, K., Baranowski, T., Ahluwalia, J., Braithwaite, R.L. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease,* 9(1), 10-21.

[63] Citation identified in GTO IPV/SV is: Turner, 2002

[64] Citation identified in GTO IPV/SV is: Resnicow, K., Soler, R., Braithwaite, R., Ahluwaila, J., Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology,* 28(3), 271-290.

[65] Definition developed by the CDC GTO IPV/SV Development Team

Data and Information Needed

When focusing on a particular faith community or partnering with the community on faith-based initiatives it is important to understand the perception of sexual violence and what is supporting it within the context of the particular religious identity. Gathering this information upfront and working to increase the capacity of the faith community's leadership first will help in making the prevention effort more successful than proposing a strategy right away.

Also consider the potential interplay between multiple religious identities that may have to work together to implement your strategy. It is best to identify those components of a strategy that are agreed upon by the multiple religious identities, and focus on strengthening them, rather than trying to change beliefs or come to consensus on historical points of disagreement.

Considerations

Sexual violence and sexuality in general are often considered private matters within many religious communities. It may be wise to expand relationships that already exist between faith leaders and the implementing or funding organization rather than forging new ground too soon.

Efforts to increase readiness to address sexual violence within a religious community should be planned prior to the implementation of a prevention strategy. Evidence of a successful strategy in one faith community may help other communities to become more ready to address sexual violence prevention.

Example

The Domestic Violence Enhancements and Leadership Through Alliances (DELTA) Program in the Winchester area of Virginia has adopted a faith based approach for preventing intimate partner violence at the four levels of the social ecology. At the individual level, the DELTA Program uses the "Love, All That and More" curriculum that has separate versions for both Christian and Jewish faiths and supplemental tools for multi-faith initiatives.

In addition, through feedback from adolescents in the faith community they learned that the contributing factors to intimate partner violence in their faith community were:

- unequal role division between boys and girls;
- learned acceptance of unequal gender norms and stereotypes;
- confusion about gender differences and acceptable vs. unacceptable behaviors; and,
- perpetration of the violent behaviors that were witnessed as children.

This information led them to implement relationship strategies with the Coalition of Parrish Nurses to work with parents to promote healthy relationships among their children and the importance of modeling respectful behaviors. In addition, the nurses received training and subsequently revised their own training manual to include a section on helping families learn about healthy relationships

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The committee that helped develop these activities also came up with the idea of inviting churches to be Healthy Relationships Churches and employ a number of ongoing prevention activities such as sermons on healthy relationships, men and women's groups that focus on healthy relationships, and a yearly parent's retreat that focuses on aspects of healthy relationships. (Based on: Promising Practices: The Winchester DELTA Project: Working at all levels of the socio-ecological model. Available at www.vadv.org/secPublications/Moving%20Upstream%203-2.pdf

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Sexual Orientation and Gender Identity

Definition

The term 'sexual orientation' means having an orientation for or being identified as having an orientation for heterosexuality, bisexuality, or homosexuality (http://www.umassd.edu/eeo/forms/adadefinitions.cfm). The term 'gender identity' refers to an individual's sense of being either male or female, man or woman, or something other or in-between.[66] http://www.nyc.gov/html/cchr/pdf/GenderDis_English.pdf).

As part of understanding sexual orientation and gender identity issues, SVPP committees also need to be aware of the term **LGBTQ,** which stands for Lesbian, Gay, Bi-Sexual, Transgender, and Questioning. The term LGBTQ includes a diverse group of people who have a sexual orientation and gender identity different from the predominant heterosexuality. Although individuals within this category have very specific ways of classifying themselves, the group as a whole does not share the same sense of belonging to the label LGBTQ and often do not share the same definition of the label LGBTQ (CALCASA, 2000).[67]

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[66] Citation identified in GTO IPV/SV is: NY City Commission on Human Rights, 2006

[67] Citation identified in GTO IPV/SV is: California Coalition Against Sexual Assault (CALCASA) (2001). *Focusing on pride: sexual assault prevention in the LGBT community* (Part 1). California

Data and Information Needed

If part of your universal or selected population, the SVPP committee will want to understand how sexual violence is perceived and experienced by LGBTQ individuals paying particular attention to within group differences. It has been difficult to determine the magnitude of sexual violence in the LBGTQ population as most LBGTQ sexual violence is not reported to the police and many large-scale studies do not include questions related to sexual orientation or gender identity (Ristock, 2005).[68]

Additionally, not all research differentiates between experiences with same sex partners and other experiences including prior opposite sex partners, stranger assaults, and child sexual abuse (Waldner-Haugrud, 1999).[69] If the SVPP committee has access to surveillance data and/or sexual violence prevalence data within the LGBTQ community, then your state or community is fortunate.

More commonly, data on risk and protective factors in the LGBTQ community will have come from a relatively small number of qualitative or quantitative sources. To gather additional information it maybe useful to contact your local agencies that serve the LGBTQ community, subscribe to LGBTQ magazines and newspapers, and/or invite knowledgeable people from the LGBTQ community to talk on the latest issues of sexual violence with the SVPP committee.

Considerations

The problem of sexual violence within same sex relationships does not always follow the accepted model of a male dominated relationship whose aim is power and control. There is a considerable amount of partner abuse that occurs in lesbian relationships that arise from a different cause with a unique set of risk and protective factors.

Furthermore, some acts of sexual violence full under the category of hate crimes committed against LGBTQ individuals. The prevention strategy chosen to address these issues will most likely be tailored and specific to the unique circumstances in which sexual violence arise among this group.

Intimate partner violence within same sex relationships takes many of the same forms as heterosexual intimate partner violence however there are

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[68] Citation identified in GTO IPV/SV is: Ristock, J. (2005). Relationship violence in lesbian/gay/bisexual/transgender/queer (LGBTQ) communities: Moving beyond a gender-based framework. *Violence Against Women: Online Resources.* Retrieved June 2008 from http://www.mincava.umn.edu/documents/lgbtqviolence/lgbtqviolence.pdf

[69] Citation identified in GTO IPV/SV is: Waldner-Haugrud, L. (1999). Sexual coercion in lesbian and gay relationships: A review and critique. *Aggression and Violent Behavior,* 4(2), 139-149.

some specific abusive behaviors that are specific to same sex relationships. This includes threats to reveal the sexual or gender identity of a partner, threats to jeopardize custody of children or immigration because of a person's sexual or gender identity, and/or threats to reveal the HIV/AIDS status of a partner (Ristock, 2005).[70] Additionally, sexual violence and other forms of violence are perpetrated against LBGT individuals as a hate crime.

Within LGBT communities there is often a reluctance to acknowledge or address sexual violence for fear of further stigmatizing LGBT individuals and relationships. Stereotypes that view gay men as overtly sexual and lesbians as nonviolent and myths that gender equality exists simply because the couple are of the same sex or that violence is mutual and involves people of equal strength impact efforts to raise awareness, provide services and prevent sexual violence (Waldner-Haugrud, 1999[71]; Ristock, 2005[72]).

Example To be developed.

Education Level

Definition A person's education level can influence how they prefer or are able to receive information, their ability to access resources, entertainment events, recreational opportunities, health care services, and educational opportunities, and where they live. Education level itself needs to be considered with other population specific contextual issues.

A key issue that may need to be taken into consideration is literacy level. If your universal or selected population has a low literacy rate, then implementing a strategy with them that requires a great deal of reading and completion of written homework may not be appropriate. Other methods of conveying and exchanging information that do not rely on extensive reading

[70] Citation identified in GTO IPV/SV is: Ristock, J. (2005). Relationship violence in lesbian/gay/bisexual/transgender/queer (LGBTQ) communities: Moving beyond a gender-based framework. *Violence Against Women: Online Resources.* Retrieved June 2008 from http://www.mincava.umn.edu/documents/lgbtqviolence/lgbtqviolence.pdf

[71] Citation identified in GTO IPV/SV is: Waldner-Haugrud, L. (1999). Sexual coercion in lesbian and gay relationships: A review and critique. *Aggression and Violent Behavior,* 4(2), 139-149.

[72] Citation identified in GTO IPV/SV is: Ristock, J. (2005). Relationship violence in lesbian/gay/bisexual/transgender/queer (LGBTQ) communities: Moving beyond a gender-based framework. *Violence Against Women: Online Resources.* Retrieved June 2008 from http://www.mincava.umn.edu/documents/lgbtqviolence/lgbtqviolence.pdf

and writing may more appropriate.

Data and Information Needed

To be developed.

Considerations

To be developed.

Example

To be developed.

Income Level

Definition

A person's income level can influence their access to resources, entertainment events, recreational opportunities, health care services, and educational opportunities and where they live. Income level itself needs to be considered with other population specific contextual issues such as racial/ethnic identity and setting issues, such as location.

For instance, a Caucasian family that lives below the poverty income level in rural Appalachia Kentucky has a population context that may be very different from a Caucasian family that lives below the poverty income level in Louisville, Kentucky. The rural family may be socially isolated due to the long distances between their home and educational/healthcare/transportation resources, while the Louisville family may be very socially connected due to being within walking distance of educational/healthcare/transportation resources. These two families may have different values, beliefs, and norms that are not only based on their income level, but location and racial/ethnic identity.

Data and Information Needed

To be developed.

Considerations

To be developed.

Example

To be developed.

Social Norms

Definition

Marital status and popular culture are other population specific contextual issues upon which people develop and base their sense of identity. The SVPP committee may identify other population specific contextual issues that are relevant to your universal and selected populations and potential strategies for these populations.

Data and Information Needed

Data from the census bureau is publicly accessible and has information on marital status and other demographic information for areas as small as census blocks. If the strategy is one that is more targeted toward a particular popular culture or developmental age, it may be helpful to research what strategies are most effective at reaching this population.

For example, Choose Respect reaches out to adolescents, ages 11 to 14, because they're still forming attitudes and beliefs that will affect how they are treated and how they treat others. Choose Respect messages are supported by a variety of materials including eCards, posters, bookmarks, pocket guides, online games, television and radio spots, activity ideas, and clickable quizzes that inspire youth to choose respect (www.chooserespect.org). These resources where designed especially to appeal to the developmental age, interests, and culture of this population. For additional information on Choose Respect and examples of successful implementation within communities, please refer to the Choose Respect website.

Considerations

Differences between groups do not always necessitate changes to your strategy. Social norms can often be a middle ground from which to approach a population with a lot of diversity.

For example, strategies that address basic developmental needs of youth in school settings have been found to be equally effective for youth of numerous ethnic, racial, and religious backgrounds (Elliot, 2004)[73].

Example

To be developed.

[73] Citation identified in GTO IPV/SV is: Elliot, 2004

Adapting Your Evidence-Supported Strategy

Adaptation: Where is the SVPP Committee?

At this point, the SVPP committee has (Wainberg et. al, 2007)[74]:

1. Optimized fidelity by documenting a list of core components for potential strategies based on the evidence supporting the use of those strategies (GTO IPV/SV Step 3 work that optimized fidelity)

2. Optimized compatibility by assessing and documenting which core components and to what extent the core components of potential strategies are compatible with the setting context or population specific contextual issues. Part of the assessment process may have also included identification, prioritization and documentation of possible adaptations of the potential strategy's core components.

3. Balanced Fidelity and Compatibility by determining one or more of the following:

    a. The potential strategy is compatible enough with our state or community context that it does not need to be adapted from the way its core components were documented in GTO IPV/SV Step 3. The conclusion is that the strategy can be implemented 'as is' and have a realistic chance of achieving the desired outcomes. Please Note: If using GTO IPV/SV, then step would be to move to GTO IPV/SV Step 5 to assess and build the capacity needed to implement the strategy.

    b. The potential strategy has some core components that are not compatible enough with our state or community context. That is, the conclusion is that the strategy requires some adaptations to make it compatible with the state or community context in order for it to have a realistic chance of achieving the desired outcomes. How to adapt your potential strategy is discussed below.

    c. The potential strategy is so completely incompatible with our state or community context that it has no realistic chance of achieving its desired outcomes and should not be implemented.

Helpful Hint: If using GTO IPV/SV, the SVPP committee

[74] Citation identified in GTO IPV/SV is: Wainberg, M., McKinnon, K., Mattos, P., Pinto, D., Mann, C., Oliveria, C., Oliveria, S., Remien, R., Elkington, K., Cournos, F. (2007). A model for adapting evidence-based behavioral interventions to a new culture: HIV prevention for psychiatric patients in Rio de Janeiro, Brazil. *AIDS Behavior,* 11, 872-883.

should examine other potential strategies before moving onto GTO IPV/SV Step 5.

d. The potential strategy is incompatible to some extent but that readiness and capacity building, rather than adaptations to the strategy is the best course of action if the strategy is to have a realistic chance of achieving its desired outcomes.

Please Note: If using GTO IPV/SV, the next step is to move to GTO IPV/SV Step 5 to build readiness and assess/build the capacity needed to implement the strategy.

The Adaptation Process

If SVPP committees did not do assessment and adaptation concurrently and the SVPP committee has determined that adaptations to the potential strategy are warranted, the next step for SVPP committees is the adaptation process. For additional information about adaptation, see **Appendix P** for **Bell et. al article** on ***Challenges in Interventions***.

Working with representatives of the setting context and the universal or selected population, SVPP committees would adapt a potential strategy by:

1. Identifying a list of possible ways to adapt the incompatible core components so that they are more compatible to the setting context or population specific context.

2. Prioritizing adaptations based on what is gained and what is lost regarding both fidelity to the evidence supporting the use of the strategy and contextual compatibility.

3. Documenting core components of the adapted strategy. During the CQI process in Step 9 Continuous Quality Improvement, the balance between the evidence supporting the use of a potential strategy and contextual compatibility can be adjusted based on evaluation results.

Please Note: If using GTO IPV/SV, GTO IPV/SV Step 9 is intended to be implemented in Year 3 or 4 of the cooperative agreement.

SVPP committees may then decide to go one or two steps further depending on their particular situations and needs. These additional steps include refinement and pre-testing:

1. Refinement includes exposing adapted strategy materials to staff who would implement the strategy and representatives of the universal or selected population to obtain feedback regarding

structure and core components. These staff members and representatives from the universal or selected population may or may not have participated in the assessment and adaptation process.

People who did not participate in the assessment/adaptation process may be able to provide a 'fresh eye' that can attest to the adapted strategy's compatibility with the state and community context. SVPP committees would make any final adaptations to the strategy based on this feedback.

2. Pre-testing is piloting the adapted strategy in one implementation site and assessing the evaluation data before implementing in other locations. During pre-testing, SVPP committees are assessing if there are any unintended or unusual side effects or harms resulting from the adapted strategy, whether the strategy was successful in achieving intended outcomes, and as an indication of the strategy's effectiveness; and if there were activities that helped to address resistance, fears, ownership, and participation of the universal or selected population and staff of the implementing organization. SVPP committees would make any final adaptations to the strategy based on this evaluation data.

Evaluation

Evaluation is essential when adapting strategies; it is how you know you are reaching the desired results as well as know if the changes made to the strategy are working. This is the main reason for including assessments of evaluation efforts and evaluation capcity in the RPE Benchmarks as well as including evaluation capacity as a component in the comprehensive primary prevention state plan.

Please refer to **The Rape Prevention and Education (RPE) Cooperative Agreement Revised Benchmarks for Success and Recommended Timelines** dated **June 25, 2008** located in **Appendix F** and the Information on Planning Components – GTO IPV/SV Step section of the guidance document for additional informational on evaluation assessments.

Action Items for this Step

The SVPP committee started the GTO IPV/SV Step 4 process with a list of potential strategies for which the core components (i.e., theory, activities, content, and structure) had been identified using the draft **Strategy Compatibility and Evidence Assessment Worksheets: Areas I and II (Appendix M)**. During the GTO IPV/SV Step 4 process, the SVPP committee should have completed or should be sure to complete the following action steps, preferably in order:

- Identified the context in which the potential strategies will be implemented: the who, with whom, and where.
- Ensured your planning team has the necessary expertise present or involved to inform an in depth contextual assessment of the potential strategies.
- Outlined a process for contextual assessment that is in alignment with the important principles (i.e., social justice, community knowledge, community ownership, inclusion, democratic participation, improvement, and accountability) as discussed earlier in the step.
- Completed a population specific and/or setting contextual assessment, as documented in Assessment Area IV of the draft **Strategy Compatibility and Evidence Assessment Worksheets (Appendix O),** for the potential strategies intended for your universal and selected populations.
- Eliminated strategies that are too incompatible, and have documented why in Assessment Areas I and II (draft **Strategy Compatibility and Evidence Assessment Worksheets, Appendix M)**
- Chosen one or more potential strategies that seem to balance fidelity to the evidence supporting the use of the strategy and compatibility to the context such that the strategy would be able to produce the outcomes desired.
- Explored the various options for making the strategy(ies) more compatible before deciding to adapt.
- Decided on adaptations that need to be made to the strategy to make it more compatible, and have documented these adaptations in Assessment Areas III and IV **(**draft **Strategy Compatibility and Evidence Assessment Worksheets (Appendix M and Appendix**

O). **Helpful Hint:** If using GTO IPV/SV, remember to update the evaluation materials accordingly in GTO IPV/SV Steps 7 and 8.

- Documented a list of capacity building needs in which to focus efforts on in GTO IPV/SV Step 5.

Outcome of Step

The GTO IPV/SV Step 4 outcomes should be:

- A narrowed/ prioritized set of strategies and/or potential strategies;
- The evidence documenting the use of the strategy in the areas of theory, content, and structure; and,
- Documentation of changes made to the strategy(ies).

This is information that will be used in the implementation of the next section, GTO IPV/SV Step 5 – Capacity.

Before Moving onto GTO IPV/SV Step 5 Capacity Building

Next Steps

To prepare the SVPP committee for GTO IPV/SV Step 5, it is important to:

- have access to the above documentation;
- ensure the necessary stakeholders and partners that will be involved in the set of prioritized strategies and/or potential strategies are present and/or represented in future capacity conversations; and,
- Review and understand the capacity building goals and outcomes developed in GTO IPV/SV Step 2 for the prevention system (optional).

Capacity Building (GTO IPV/SV Step 5)[75]

Introduction

The successful development, implementation, and maintenance of sexual violence evidence – supported strategies and a prevention system (optional) require that certain abilities or capacities to be present. GTO IPV/SV builds on the work completed in previous steps by addressing the capacities needed by individuals, organizations, and prevention systems to successfully implement potential and/or specific evidenced support strategies and to build the prevention system (optional).

This section provides an overview of GTO IPV/SV Step 5 – Capacity, why this step is important, key terms used in this step, understanding capacity, assessing and building capacity for evidence – supported strategies and building prevention system capacity (optional).

With information provided in this section, the SVPP committee would identify the capacities currently in place and the capacities needed to implement potential and/or specific sexual violence evidence - supported strategies identified for their universal, selected populations and to build your prevention system (optional).

Please Note: As a reminder building capacity for the prevention system is optional; it is not required. Prevention system capacity information is discussed in the latter part of this section.

There is an iterative nature of GTO IPV/SV that is presented when addressing GTO Steps 3-5 for evidence - supported strategies. The iterative process involves:

- documenting sufficient evidence supporting the use of a strategy (GTO IPV/SV Step 3).
- addressing any contextual issues that would affect implementation (GTO IPV/SV Step 4)l and,
- identifying the capacities needed to successfully implement a strategy that is compatible with its implementation context (GTO IPV/SV Step 5).

[75]Portions of the section are adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual, including DELTA and EMPOWER Cooperative Agreement grantee meeting presentations. The information provided are the major concepts needed to implement the process. The following sections will be updated and revised as the completed steps become available.

Furthermore, in terms of the capacity needed to implement and maintain evidence – supported strategies, GTO IPV/SV Step 5 builds upon work done in:

- GTO IPV/SV Step 3 by ensuring that the capacities needed for successful implementation are addressed.
- GTO IPV/SV Step 4 by ensuring that the capacities needed to support and retain adaptations needed for strategy compatibility with the current state and community context are addressed.

Why is This Step Important?

GTO IPV/SV Step 5 focuses on assessing and building capacities for the implementation of potential and/or specific evidence – supported strategies and to build the overall prevention system (optional). It is important to assess capacity before strategy implementation because capacity directly relates to how well the strategy will be implemented. If there is not enough capacity to implement the strategy as intended, then it is likely that the program will not achieve the outcomes desired (Chinman et. at., 2004).

It is important to know what capacities the community and state, already has and which ones are needed to implement the strategy with high quality. Some strategies may be too difficult or resource intensive for an organization to deliver with quality, for example.

In cases where the community and/or state does not possess adequate capacities, a clear plan will need to obtain or access them elsewhere, modify projects and programs so that they require fewer resources, or choose different projects and programs that require fewer resources will need to be developed (Fisher, 2006).

Building capacity to successfully implement evidence supported strategies and to develop prevention system (optional) can lead to:

- Increased stakeholder participation;
- Improved problem assessment ;
- More local leadership;
- Strengthened linkages between organizations, communities and individuals;
- Increased resource mobilization and utilization;
- Enhanced stakeholder control and input in program management;

- More empowering organizational structures; and,
- More equitable relationship with outside agents

Here are some of the key terms[76] to become familiar with while reading this section.

Capacity	Characteristics of individuals, organizations or prevention systems that affect their ability to identify address and mobilize to prevention sexual violence.
Cultural Competency	A developmental process that results in individual, organizational, and prevention system understanding of cultural differences and similarities within, among, and between communities, cultures and populations. This competence requires drawing on the community-based values, traditions, and customs to work with knowledgeable persons of and from specific populations in developing specific strategies and communications to address their needs.
Evaluation Capacity	The extent to which an individual, organization or prevention system has the necessary resources and motivation to conduct, analyze, and use evaluations to improve strategies and prevention capacity.
Individual Capacity	The characteristics such as knowledge, skills, resources, and motivation that are necessary for individuals to identify, address, and mobilize to prevent sexual violence.
Organizational Capacity	The characteristics such as structures, processes, strategies, resources, and willingness that are necessary for a formally and/or informally structured group or organization to identify, address, and mobilize to prevent sexual violence

[76] If not cited, the key terms are developed and/or adapted by the CDC GTO IPV/SV Development Team in the development of the GTO IPV/SV.

Prevention Capacity

The extent to which an individual, organization, or prevention system has the motivation and ability to use the 4-step public health[77] approach to address and prevent pubic health problems such as sexual violence from initially occurring.

Prevention System[78]

The Sexual Violence Primary Prevention System is a network of organizations[79] and individuals at the state and/or community level that supports and expands the work of the 4-step public health approach[80] to addressing sexual violence.

Readiness

The motivations and willingness of an individual, organization or prevention system community to develop and implement sexual violence prevention programming.

Helpful Hint: It is important to understand the difference between capacity and readiness. Capacity and readiness interact and are important to consider when planning how to implement the evidence – supported strategies and to develop the capacity of the prevention system. The capacity and readiness interaction could occur in three ways:

- Having the capacity for implementation but lacking the motivation or willingness for the needed implementation. In this situation, readiness may have to be developed prior to the actual implementation of the prevention effort.
- Having readiness for implementation, but lacking the necessary capacities for implementation. In this situation, as readiness already exists, capacity development would be the appropriate next step.
- Lacking ***both*** capacity and readiness for implementation. In this situation, readiness for implementation should precede capacity building efforts.

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[77] Step 1: Define and Measure the Problem; Step 2: Identify Risk and Protective Factors; Step 3: Identify Effective Strategies; Step 4: Disseminate Effective Strategies

[78] Definition developed by the CDC GTO IPV/SV Development Team and MPR Workgroup

[79] Coalitions, partnerships, local or state government agencies, or nonprofit agencies and their respective stakeholders

[80] Step 1: Define and Measure the Problem; Step 2: Identify Risk and Protective Factors; Step 3 Identify Effective Strategies; Step 4: Disseminate Effective Strategies

Benefits to Building Capacity

As seen from the definitions above, there are various types of capacity. Building capacity for the implementation of your strategy can help SVPP committees to:

- identify which additional stakeholders need to be involved in developing specific strategies as well as the overall plan;
- narrow your choice of strategies to implement as you may not be able to build the adequate capacity or readiness for certain strategies or you need to revisit some compatibility issues (GTO IPV/SV Step 4); and,
- ensure adequate capacity for quality implementation of strategies.

Insufficient capacity can lead to little change of substantially preventing sexual violence as well as:

- waste valuable time and resources;
- lead to poor implementation of strategies that have no realistic chance of achieving the goals and outcomes; and,
- lead to fragmented prevention system capacity efforts that lack evidence and contextual support.

Types of Capacity

There are various types of capacity e.g. staffing, resources, partnership, fiscal are needed for successful strategy implementation. GTO IPV/SV Step 5 addresses the three **types** of capacities: that are more closely associated with the implementation of evidence – supported strategies; these **types** are:

- Prevention
- Cultural Competency
- Evaluation

Prevention Capacity

Definition

The extent to which an individual, organization, or prevention system has the motivation and ability to use the 4-step public health[81] approach to address and prevent pubic health problems such as sexual violence from initially occurring.

Prevention capacity supports the ability to implement a specific strategy; and it may include specific capacity needs related to prevention knowledge and skill development. This capacity addresses content such as addresses content such as understanding of health promotion vs. deterrence approaches to behavior change; implementing a strategy with fidelity to the evidence-supporting it.

Cultural Competency

Definition

A developmental process that results in individual, organizational, and prevention system understanding of cultural differences and similarities within, among, and between communities, cultures and populations.

This competence requires drawing on the community-based values, traditions, and customs to work with knowledgeable persons of and from specific populations in developing specific strategies and communications to

[81] Step 1: Define and Measure the Problem; Step 2: Identify Risk and Protective Factors; Step 3: Identify Effective Strategies; Step 4: Disseminate Effective Strategies

address their needs

Cultural competency supports the adequate and appropriate integration of the needs of the universal or selected population into the implementation of the specific evidence-supported strategy. This capacity contributes to successful strategy implementation and ultimately sustainability as well as supports the capacity needed to appropriately interact with populations with different backgrounds and needs. It focuses on the values, beliefs, practices or needs of a universal or selected population.

The iterative nature of GTO IPV/SV could lead to building the cultural competency to interact with various populations may need to precede some of the work of GTO IPV/SV Step 4.

Tools and/or Resources

Various resources for assessing and/or building this type of capacity:

- National Center for Cultural Competency provides Tools and Processes for Self-Assessment for individual and organizational levels;
- Using Cultural Broker Programs; and,
- Community Tool Box

Evaluation Capacity

Definition

The extent to which an individual, organization or prevention system has the necessary resources and motivation to conduct, analyze, and use evaluations to improve strategies and prevention capacity.

Evaluation capacity considers what initial capacities will be needed to carry out the evaluation that will assess and improve strategies. It focuses on content such as:

- understanding the differences between process and outcome evaluation; and,
- establishing a data collection, analysis, or reporting process.

Please Note: Evaluation is essential; it is important to know how and if the implemented evidence – supported strategy is reaching the desired goals. This is the main reason for including assessments of evaluation efforts and evaluation capacity in the RPE Benchmarks as well as including evaluation capacity as a component in the comprehensive primary prevention state plan.

Balancing Capacities

A balance needs to be kept between prevention, cultural competency and evaluation capacities. Capacity at the center is critical and must be anchored among each of these in order to achieve successful implementation.

Capacity is the anchor that significantly influences successful or unsuccessful implementation outcomes. It is important to build the three types of capacity with the compatibility needs of the implementation context. Thus in GTO IPV/SV Step 5, SVPP committees should assess whether the capacities of the prevention system (optional), organization, or individual staff members are sufficient for strategy implementation based on the adaptations, needed to balance fidelity to the evidence supporting the use of the strategy and compatibility to the implementation context.

Balancing the Types of Capacities Framing Questions

Here are some framing questions to discuss with the SVPP committees on defining cultural competence for evaluation in multicultural settings. The questions provide some examples of what to contemplate and balance in SVPP committee planning conversations.

- How will you prepare for defining evaluation within a cultural context?
- What is your understanding relationships between types of capacity
- What does cultural competence look like? What would you see evaluators doing that exemplified cultural competence?
- How would you consider the definition of cultural competence as it relates to evaluation practice?

There may be other framing questions SVPP committees may need to discuss related to the balance between prevention and cultural competency or prevention and evaluation.

Levels of Capacity

Within each capacity **type** there are different **levels** for assessing and building capacity. The capacity level needed will depend on the:

- special sexual violence prevention strategy;
- contextual areas;
- who is implementing the strategy; and,
- where is the strategy being implemented.

There are three **levels** of capacity. For evidence – supported strategies there are **two levels** capacity:

- Individual level – which focuses on the individual practitioner and the knowledge, skills, resources and motivations of the individual practitioner; and,
- Organizational level – which focuses on the implementing organizations and the structures, processes, strategies, resources and willingness of the implementing organization.

These two levels can be addressed separately or simultaneously. The multiple levels of capacity suggest a building hierarchy as change at one level may be associated with change at other levels. This is an important factor to consider when determining how to assess and build capacity.

The **third level** of capacity is prevention system, which will be discussed in more detail later in the section.

Please Note: Information and assessments related to prevention system capacity is optional; it is not required as part of the RPE Benchmarks or RPE planning process.

Assessing and Building Capacity for Evidence – Supported Strategies

Assessing Capacity

One way to identify general capacities and strategic specific capacities is through the GTO IPV/SV Step 1 process. During the GTO IPV/SV Step 1 process, SVPP committees collected capacity information as part of implementing the below RPE assessments:

- assessment and analysis of current state and local prevention programming capacity;
- assessment of current evaluation capacity and evaluation efforts; and,
- assessment and identification of state health department and potential partners to provide training and technical assistance to state and local programs on prevention programming and evaluation

The assessment information identifies which capacities are available and those that are needed. In addition, assessing capacities inform whether the organization or individual staff member's capacities are sufficient for strategy implementation.

Please Note: Refer to the RPE Benchmarks as well as the Information on Planning Components – GTO IPV/SV Step 1 for assessment information.

Tools and/or Resources

The tools identified below can be used to access individual and organizational general and specific capacities (prevention and evaluation) for implementing evidence- supported strategies:

- **Primary Prevention Activities Among Rape Prevention and Education (RPE) Funding Recipients Questionnaire (Appendix G)**;
- **Primary Prevention Activities Among Organizations Without Rape Prevention and Education (RPE) Funding Questionnaire (Appendix H)**;
- **State Level Interview Guide (Appendix I)**
- The optional **Sexual Violence Prevention System Capacity**

Assessment (Appendix J) can be used to assess organizational prevention capacity.

Please Note: The optional prevention system capacity tool referenced above is not required; it is provided as a resource.

Tools and/or Resources

When assessing the contextual issues for the potential strategy, the SVPP committee should assess the capacities for strategy implementation at the same time. The draft **Strategy Compatibility and Evidence Assessment Worksheet**, **Assessment Area IV (Appendix O)** will aid SVPP committees identify and document capacities for strategy implementation.

In addition, the worksheets could be used to document the information obtained from the GTO IPV/SV Step 1 assessments.

Building Capacity

Capacity emphasizes building the positive components of an individual or organization as a means for addressing its needs. Strengthening capacity is essential for strategy implementation as well as for the sustainability for the Comprehensive Primary Prevention Plan. In addition, SVPP committees may identify the need to build capacity in one or more of the below areas to support strategy implementation:

- Policies
- Funding mechanisms
- Training
- Technical assistance and/or coaching
- Monitoring

In building capacity, SVPP committees may also need to consider:

- organizational stability and viability (e.g. viability often requires new funding sources leading to more staff and programs, diversified selected populations and more partnerships); and,
- organizational commitment to sexual violence (e.g. leadership and vision).

Capacity building is essential to program sustainability because initiating a strategy in a state or community without careful thought or without stakeholder involvement does not equal success. Capacity building should be structured to:

- strengthen the state's or community's ability to take and sustain action;
- acknowledge existing resources and assets; and,
- acknowledge training and technical assistance are important means to build prevention, cultural competency and evaluation capacity.

Various types of capacity are needed for successful strategy implementation. The GTO IPV/SV manual focuses on the three types of capacity (prevention, cultural competency, evaluation) that are closely related to the successful implementation of evidence- supported strategies. Below are a few recommendations on how to build capacity within the three capacities.

Prevention Capacity

Ongoing training at the individual level increases knowledge and providing technical assistance can also increase the utilization of that prevention knowledge.

To build capacity at the organizational level, changing mission statements, addition of prevention efforts in job announcements, having strategic plans or in-service trainings to reflect the core principles of prevention.

Cultural Competency Capacity

To build organizational capacity in cultural competency, the organization should routinely review their capacity building materials (e.g. training curricula, questionnaires, manuals) and delivery techniques with members of the group that they are implementing the evidence – supported strategy with to ensure sensitivity and effectiveness.

For individual level capacity, should discuss with staff members about the importance to pay attention to how your own assumptions and cultural background could affect interactions with other people as well as the population implementing the evidence – supported strategy with.

Evaluation Capacity

Purposely create structures or mechanisms within the organization that enables the development of evaluation capacity. In addition, building individual capacity achieves a higher level of data collection and analysis competence when individuals have the opportunity to use inquiry skills and receive feedback about how well they are doing.

Building Implementation Readiness

Readiness can be a capacity building approach the SVPP committees may want to improve prior to choosing a strategy. Assessing the readiness of the implementation context should have occurred in GTO IPV/SV Step 4. Building readiness within a location (where the strategy will be implemented) or organization (who is implementing the strategy) may be a large task and not feasible to improve prior to implementation at this step in the GTO IPV/SV process.

In addition, SVPP committees identified readiness issues relevant to the particular universal and selected populations whom working with or want to work with (e.g., history, language, needs, assets, value systems) in GTO IPV/SV Step 1. This information will help decide if readiness needs to be built before capacity building activities.

Readiness Framing Questions

Based on the readiness based of the implementation context (where the strategy will be implemented), strategy implementation may/may not be feasible. Here are some questions to consider if readiness is an issue in this step of the process.

1. Has readiness been assessed?
2. Can readiness be improved prior to implementation at this step in your process? If so, how?
3. How will the strategy be implemented?
4. Is there buy-in, investment, and collaboration?

For example, as the implementing organization, well trained staff is an important approach to building readiness. It may not be feasible to train the whole organization trained to a point of readiness for implementation. However, getting key staff trained who are involved in the strategy implementation may be the best use of time and resources. Building the readiness of the overall organization may be a later goal.

Assessing and Building Capacity for the Prevention System (optional)

Introduction

One outcome of GTO IPV/SV Steps 1 and 2 is the assessment and identification of sexual violence prevention system capacity (PSC) goals and outcome statements from the **Sexual Violence Prevention System Capacity Assessment (Appendix I)**. When the assessment was completed, a logic model for prevention system capacity goals, outcome statements and strategies should be developed.

The Sexual Violence Primary Prevention System[82] is a network of organizations[83] and individuals at the state and/or community level that supports and expands the work of the 4-step public health approach[84] to addressing sexual violence. This network is referred to as a prevention system due to:

- the responsibility to prevent sexual violence *not* belonging to any singular organization or group;
- the network having a dynamic nature that is influenced by internal and external issues; and
- the whole system being greater than the sum of its parts.

Prevention System is the **third level** for addressing capacity. An important aim of capacity building is to lead to sustainable solutions and resilience. One of the strengths of the capacity building approach is its eye to the longer term, which is important factor of GTO IPV/SV Step 10 (Sustainability). Prevention system capacity is important to sustainability efforts.

Tools and/or Resources

Appendix N provides a recommended **GTO logic model format** for building **prevention system** capacity.

Please Note: **It is not required** for RPE Part A grantees to assess and/or build prevention system capacity, to develop and/or implement

[82] Definition developed CDC GTO Development Team and MPR Workgroup

[83] Coalitions, partnerships, local or state government agencies, or nonprofit agencies and their respective stakeholders

[84] Step 1: Define and Measure the Problem; Step 2: Identify Risk and Protective Factors; Step 3 Identify Effective Strategies; Step 4: Disseminate Effective Strategies

prevention system goals and outcome statements or to submit a prevention system logic model with the comprehensive primary prevention state plan; **all of the above actions are optional.**

Why is Prevention System Capacity Important?

As mentioned earlier, the important aim of capacity building is to lead to sustainable solutions and resilience; it is not just about allocating money and resources to fix something in the short term but about building physical and social infrastructure to support sustainability.

Having a functional sexual violence prevention system is essential for strategy implementation as well as for the sustainability for the Comprehensive Primary Prevention Plan.

Sustainability can come from integrated and linked efforts across a range of state and community agencies focused on improving the broader system of prevention. This is achieved by working together to draw upon the complementary expertise and diverse perspectives.

In addition, building capacity for your prevention system can help:

- identify state and community resources and infrastructures to be further developed; and,
- improve collaboration through networking and coordination of efforts.

Assessing Prevention System Capacity

As a reminder, In GTO IPV/SV Step 1 prevention system capacities were addressed (optional) using the recommended **Sexual Violence Prevention System Capacity Assessment** (**Appendix I**). This instrument provides SVPP committees with a method to self-asses their prevention system.

Utilizing the recommended assessment instrument can guide SVPP committees through a process of reviewing the components of the primary prevention system, while identifying areas of strength as well as those in need of development. In addition, the prevention system assessment may facilitate discussion and exchange of information among SVPP committee members for the purpose of planning how to build primary prevention system capacity. Also the instrument can be used as a method to routinely assess capacity building overt time.

Characteristics of Prevention Systems

Prevention system capacity begins with an understanding of the System profile, that is considering the existing environment, relationships, and challenges that the state and/or community sexual violence prevention system operates in, and the key influences and/or constraints on the system.

The prevention system is further characterized by these multiple dimensions:

- o leadership – considers the leadership environment in the state or community;
- o strategic planning – considers the development of state or community –wide strategic objectives and action plans around sexual violence prevention;
- o information – considers the current state of measurement, analysis, and management of information for knowledge- driven performance in the state or community sexual violence prevention system;
- o community and constituency focus – considers how the state or community sexual violence prevention system involves, understand, and maintains accountability to sexual violence prevention constituencies and communities;
- o human resources – considers the organization, development, and support of the workforce around sexual violence prevention across the state or community;
- o system operations – considers the core operational programs, processes, and strategies that achieve results in sexual violence prevention across the state or community; and,
- o results/outcomes – considers the achievements of the state or community sexual violence prevention systems as demonstrated through identified near and long term performance indicators.

The prevention system capacity assessment was completed (GTO IPV/SV Step 1) and goals and outcome statements were developed in GTO IPV/SV Step 2. At this point, the SVPP committee may want to add and assess newly identified capacities as a result of working through GTO IPV/SV Steps 3 and 4. Ultimately the prevention system goals identified in GTO IPV/SV Step 2 should reflect the capacity building needs identified in GTO/IPV Step 5.

The draft **Strategy Compatibility and Evidence Assessment Worksheet**, **Assessment Area V (Appendix O)** will aid SVPP committees to document capacities for prevention system. In addition, the worksheets could be used to document the information obtained from the GTO IPV/SV Step 1 assessments.

Building Prevention System Capacity

To successfully build a sexual violence prevention system based on the capacity goals developed in GTO IPV/SV Step 2, it requires that SVPP committees to:

- document how they plan to build that capacity; and,
- determine if capacity goals are not feasible at this time

The prevention system capacity goals will reflect additional capacities needed, thus the SVPP committee may need to revisit GTO IPV/SV Step 2 to revise the prevention system capacity goals especially if some of the capacities are not currently feasible.

Tools and/or Resources

The draft **Strategy Compatibility and Evidence Assessment Worksheet**, **Assessment Area V (Appendix O)** will aid SVPP committees in documenting the capacities for the prevention system. In addition, the worksheets could be used to document the information obtained from the GTO IPV/SV Step 1 assessments (**Sexual Violence Prevention System Capacity Assessment (Appendix I)**.

Research on building the capacity of a prevention system is rare and relatively new. Thus, most of research literature regarding capacity building strategies comes from case studies that describe lessons learned. It is recommended to u utilize the best available evidence in combination with practitioner knowledge to determine how to build the capacity your prevention system.

Here are two recommended examples for building capacity on the leadership and information dimensions of the prevention system.

Leadership

To create a unified and sustainable sexual violence prevention system, members must be engaged in the planning process. This process may take form as bottom-up, participatory in decision-making, but nonetheless should be structured to engage and support the entire system. This process can begin by reflecting the importance of shared responsibility when developing and implementing a vision for sexual violence prevention. Leadership is an important element in achieving the vision.

Building leadership for prevention system capacity focuses on individual members and the relationships within their organizations including funded programs. Building leadership starts with determining where the leadership is focused.

Specifically, here are some recommendations for building prevention system capacity for leadership. Building leadership:

- reflects collective vision, mobilizes political will, supports relationships and enforces infrastructure;
- develops and nurtures shared leadership of both formal and informal local leadership through acknowledgement and encouragement of community members' voices;
- involves bringing people with diverse skill sets together under a strategic vision for the future;
- mobilizes financial and organizational resources within a geographic region and facilitation of networks to build on existing infrastructures and resources;
- engages stakeholders and coalitions to plan and implement;
- promotes readiness where needed; and,
- focuses on sustainability.

Information System

Building information systems for prevention system capacity can educate community stakeholders and policy makers, build awareness, guide in-depth research and evaluate change over time. An information system and proper dissemination of information communicates the relevance of sexual violence and its prevention to collaborators but to also those not traditionally dedicated to sexual violence prevention.

Establishing a systematic approach to measurement and analysis is essential to building a broad prevention system, securing resources, and making new partnerships. Improving the performance for information systems whether state or county, could be achieved by:

- setting minimum standards for surveillance capacities;
- identifying specific sexual violence related injuries, risk and protective factors, data sets (behavior and attitudinal); and
- integrating the information systems to better support sexual violence prevention programs and policies.

Logic Model

When the assessment is completed and capacities have been documented, a logic model for prevention system capacity goals, outcome statements and strategies should be developed.

Tools and/or Resources

Appendix N provides a recommended **GTO logic model format** for building **prevention system** capacity.

Please Note: **It is not required** for RPE Part A grantees to assess and/or build prevention system capacity, to develop and/or implement prevention system goals and outcome statements or to submit a prevention system logic model with the comprehensive primary prevention state plan; **all of the above actions are optional.**

Implementation of GTO IPV/SV Steps 3-5 at the State Level

Introduction

SVPP committees implemented GTO IPV/SV Steps 3-5 for the identification and selection of evidence – supported strategies for their universal and selected populations. This section discusses what state level strategy implementation could look like other than strategies for building prevention system capacity (optional).

In addition, this section highlights three possible processes for identifying and refining strategies for the universal and selected populations and known risk and protective factors associated with those populations.

As a state agency and/or state entity (e.g. state sexual assault coalition, SVPP committee), there are natural roles for supporting local strategy implementation. Some of the natural state roles are to:

- promote and champion strategy implementation;
- provide training and technical assistance for implementation;
- build capacity for strategy implementation;
- institutionalize strategy via the Comprehensive Primary Prevention Plan and in local grants and contracts;
- provide support for evaluation and acknowledge and celebrate programmatic improvements at conferences, etc;
- monitor strategy implementation as funder and convener of local programs; and,
- provide sustainability and funding to support ongoing implementation.

What does Strategy Implementation look like at the State Level?

At the minimum, state agencies, state partners and/or SVPP committees should be able to communicate what the core components are of the potential strategy. Below are three scenarios that the state agency, state partners and/or SVPP committees may consider in planning.

Scenario 1

Identify core components and adaptation recommendations for strategy implementation:

1. Identify the core components of chosen strategy; this step is done using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III (Appendix M)** in GTO IPV/SV Step 3.

2. Identify the extent to which fidelity must be maintained to the components and give adaptation recommendations for local implementation; this process is the outcome of GTO IPV/ SV Step 4 using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O).**

3. Identify the capacities needed to implement core components and do adaptation; this process is the outcome of GTO IPV/SV Step 5, draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)**.

4. Institutionalize local implementation of core components into the Comprehensive Primary Prevention Plan – GTO IPV/SV Step 6.

Benefits to Scenario 1

The benefits of using Scenario 1 are:

1. The assumption of adaptation is not overly prescriptive; while the core components may not change, there might be different ways to implement them.

2. Promotes improvement; the strategy implements components that are essential thus making it more likely to succeed.

3. Supports community specific adaptations which allows for better buy-in of the strategy.

Limitations to Scenario 1

The limitations of using Scenario 1 are:

1. It may be hard to do quality assurance across strategies when they have been adapted.

2. Addressing the varying technical assistance needs of the implementing organization; each program would need specialized technical assistance based on what adaptations were made and why.

3. Lack of statewide consistency in the implementing programs may

make it harder to determine and describe implementation across the state.

After the completion of GTO IPV/SV Step 3, the SVPP committee could have a menu of potential strategies that have been identified for the universal and selected populations. Of those strategies, there may be some that the SVPP committee is more comfortable with and there may be some that the committee may want to explore further.

States and/or SVPP committees might want to consider pilot testing to determine how much they are willing to support the strategy statewide. It is an opportunity to learn more about the strategy and how they are implemented at the local level.

Scenario 2

Process to follow if going to pilot test a strategy:

1. Choose a strategy by using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III (Appendix M)** assessment information to determine the components and what can be adapted; this is the outcome of GTO IPV/SV Step 3.

2. Identify unique risk and protective factors for the population. In this process, the use of data to adapt and refine the strategy may be needed. In addition, communities to pilot test the adapted strategy may need to be identified; what are the risk and protective factors and contextual considerations for those communities. This process is the outcome of GTO IPV/ SV Step 4, draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV, Appendix O)**.

3. Identify the capacities needed for pilot testing and local implementation; this process is the outcome of GTO IPV/SV Step 5, draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)**.

4. Devise a plan for pilot testing that would be included in the Comprehensive Primary Prevention Plan (GTO IPV/SV Step 6).

Benefits to Scenario 2

The benefits of using Scenario 2 are:

1. Supports local implementation of the evaluated strategies for specific populations; local programs would appreciate finding out first how likely this is to work in their community.

2. Allows for evaluation results before community wide adoption.

3. Longer time-frame for completion than piloting as part of the planning process.

Limitations to Scenario 2

The limitations of using Scenario 2 are:

1. Potential limited applicability to other communities.

2. Requires significant resources and capacity.

Scenario 3

This scenario proposes to implement a pilot test whether as part of the planning process or as part of the Comprehensive Primary Prevention Plan in a phased approach. The process would be:

1. Choose a strategy by using the draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Areas I, II, III (Appendix M)** assessment information to determine the components and what can be adapted; this is the outcome of GTO IPV/SV Step 3.

2. Use data to adapt and refine the strategy (outcome of GTO IPV/ SV Step 4, draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)** and conduct pilot testing with a sample of universal and/or selected populations.

3. Identify the capacities needed for pilot testing and local implementation; this process is the outcome of GTO IPV/SV Step 5, draft **Strategy Compatibility and Evidence Assessment Worksheet, Assessment Area IV (Appendix O)**.

4. Devise a concrete local implementation plan that would be part of the Comprehensive Primary Prevention Plan.

Benefits to Scenario 2

The benefits of using Scenario 2 are:

1. Supports local implementation of evaluated strategies for specific populations.

2. Allows for evaluation results before community wide adoption.

Limitations to Scenario 2

The limitations of using Scenario 2 are:

1. Potential limited applicability to other communities.
2. Requires significant resources and capacity.
3. Possible SVPP committee time commitment.
4. Possible delay in Comprehensive Primary Prevention Plan release.

Comprehensive Primary Prevention Plan Guidance (GTO IPV/SV Step 6)

Purpose of Plan

The Comprehensive Primary Prevention Plan (GTO IPV/SV Step 6) should demonstrate a shift in RPE prevention programming from awareness and risk reduction activities and strategies to primary prevention strategies and programs.

By the beginning of Year 3 (January 2009), the SVPP committees should have components or a draft comprehensive primary prevention plan that is realistic and based upon existing capacity and infrastructure to implement the plan.

It is important for SVPP committees to remember to plan within their program infrastructure e.g. monetary resources, capacity and staff to support and sustain implementation efforts.

Plan Life

SVPP committees should create a comprehensive primary prevention plan timeline for 3-8 years; the minimum is 3 years.

Plan Due Date

The Comprehensive Primary Prevention Plan is due **June 2009** with the RPE continuation application.

Plan Components

This section describes the CDC recommended components of the Comprehensive Primary Prevention Plan (GTO IPV/SV Step 6)[85].

In addition, this section provides guidance on how to include logic models and narratives in the Prevention Plan.

[85] This Guidance Document section is based on the IPV/SV Primary Prevention Plan Guidance created by the CDC GTO Development Team for the DELTA and EMPOWER cooperative agreement grantees.

Recommended Plan Components

Prefix

1. Table of Contents
2. List of Sexual Violence Prevention Planning Committee (SVPPC) members at time Plan was developed
3. List of SVPPC member's affiliations that:
   - o describe how the SVPPC members were recruited and what agency/organizations they represented; and,
   - o describe planning process
4. Purpose of Comprehensive Primary Prevention Plan (Plan)
5. Shared Definition of Sexual Violence used by SVPPC members
6. Shared Prevention Vision used by SVPPC members
7. Letters of Endorsement/Letter of Support of Plan from high ranking official e.g. Governor, Attorney General, Public Health Commissioner
8. Forward by the Sexual Violence Prevention Planning Committee that describes the significance of Plan
9. Executive Summary that describes key findings/conclusions for each Step/process

Needs and Resources Assessment & Goals and Outcome Statements (GTO IPV/SV Steps 1 and 2)

A chapter with the following information:

1. Geographic area of interest defined and described
2. A State Assessment that includes:
   - o review of present demographic data;
   - o review of present economic data;

- description of present influential circumstances in the state;
- listing of present assets and resources in the state; and,
- separate profiles for each major region or county within the state (depending on size of state)

3. Data presented on magnitude of sexual violence which includes:
   - magnitude of sexual violence in the state; and,
   - magnitude of sexual violence is examined for sub-populations in the state
4. Data presented on potential risk and protective factors across social ecology which includes:
   - description of risk and protective factors for sexual violence across the social ecology; and,
   - description of risk and protective factors for sexual violence across the social ecology for sub-populations in the state
5. Description of the universal and selected populations that will be addressed by this Plan
6. Description of the various data sources, quantitative and qualitative e.g. community knowledge, secondary data from state and national survey, etc are utilized and triangulated to inform the development and prioritization of goals
7. Gaps are identified in the state's ability to track magnitude of sexual violence
8. A list of prioritized goals and rationale is provided
9. At least one goal for an universal population that includes at least one outcome statement that clearly addresses the Audience, Behavior, Condition, Degree and Evidence[86] (ABCDE)
10. At least one goal for a selected population that includes at least one outcome statement that clearly addresses ABCDE
11. Optional: At least one goal for prevention system capacity that includes at least one outcome statement that clearly addresses

[86] Audience = who will change; Behavior = what will change; Condition = by when; Degree = by how much; Evidence = how will the change be measured

ABCDE

12. Goals that cover a 3-8 year time frame

13. Goals are changed-based

Evidence-based Prevention Strategies, State and Community Context, and Capacity (GTO IPV/SV Steps 3 -5)

This chapter should describe how the Sexual Violence Prevention Planning Committee would address the goals and outcome statements for universal and selected populations and the prevention system (optional).

Strategies for Universal and Selected Populations

This chapter describes how the Sexual Violence Prevention Planning Committee weighed the available evidence and considered state or community contextual issues and capacity issues as they determined which strategies to implement to meet the goals associated with their universal and selected populations.

Sexual Violence Prevention Planning Committee members describe the areas of conflict and compromise, new synergies, and unique opportunities they encountered as they deliberated the various issues identified in GTO IPV/SV Steps 3-5. Key areas discussed include:

1. what evidence-based strategies to use (GTO IPV/SV Step 3),
2. how state or community contextual issues influenced their choice of strategies (GTO IPV/SV Step 4),
3. how state and community contextual issues influenced how they adapted their chosen strategy (GTO IPV/SV Step 4), and
4. how current state or community capacity was sufficient to implement the chosen strategies or needs to be enhanced to allow for implementation of the chosen strategies (GTO IPV/SV Step 5).

<u>Optional</u> Prevention System Capacity

This chapter also describes how the Sexual Violence Prevention Planning Committee weighed the available evidence and the needs and capacity of the prevention system as they deliberated how to build the capacity of the prevention system.

Sexual Violence Prevention Planning Committee members describe the areas of conflict and compromise, new synergies, and unique opportunities

they encountered as they deliberated building the capacity of the prevention system in one or more of the following areas:

1. System Profile
2. Leadership
3. Strategic Planning
4. Community Focus
5. Human Resources
6. System Operations
7. Information (data collection, analysis, and management)
8. Results/Outcomes Documented

Step 6 **Putting It All Together**

A chapter that contains

1. Introduction of the Plan
    a. Brief description of your process
2. Prevention System Capacity (optional)
    a. Logic Model for Prevention System Capacity;
    b. Narrative that describes the Goal(s), Inputs, Strategies/Tasks, Outputs, Short-term Outcomes, Long-term Outcomes, and Contextual and Influential Factors
    c. A timeline detailing when Strategies/Tasks listed on the Logic Model would be implemented and by whom.
3. Universal Population Prevention Strategy(ies)

a. Logic Model for activities and/or strategies[87] for Universal and Selected Populations.

b. Narrative that describes the Goal(s), Inputs, Strategies/Tasks, Outputs, Short-term Outcomes, Long-term Outcomes, and Contextual and Influential Factors

c. A timeline detailing when Strategies/Tasks listed on the Logic Model would be implemented and by whom.

4. Selected Population Prevention Strategy(ies)

a. Logic Model following the GTO Logic Model format for Universal and Selected Populations

b. Narrative that describes the Goal(s), Inputs, Strategies/Tasks, Outputs, Short-term Outcomes, Long-term Outcomes, and Contextual and Influential Factors

c. A timeline detailing when Strategies/Tasks listed on the Logic Model would be implemented and by whom.

Appendices

This section of the Primary Prevention Plan can include materials that are too detailed and lengthy to include in a particular chapter.

Logic Models and Narratives

Logic Models

The Comprehensive Primary Prevention Plan should include logic models, narratives, and timelines. The logic models will be accompanied by narratives that vividly describe the various components of the logic model as well as a timeline that details what will take place when. **Appendix L** provides a recommended **GTO format for logic model development**.

When developing logic models that address the needs of a specific group, it is important to have representatives from that group participate in the overall planning process, including the development of the logic models.

If you need additional information regarding the RPE Theory and Activities

[87] If creating a statewide plan that's broader than the RPE program, please create two logic models. The first logic model should be for the RPE program only. The second logic model should be for the broader statewide sexual violence efforts.

models, please refer to the RPE Theory and Activities Models and Program Planning section of the guidance document.

If the SVPP committee has developed goals, outcome statements and identified strategies for the prevention system, **Appendix N** has a recommended format for the **GTO prevention system capacity logic model**.

Please Note: If creating a statewide plan that's broader than the RPE program, please create two logic models. The first logic model should be for the RPE program only. The second logic model should be for the broader statewide sexual violence efforts.

Connecting Logic Model Components to GTO Steps

Logic Model and Narrative Elements	GTO Step Providing Content
	Universal and Selected Populations and Prevention System Capacity (optional)*
Goal Statement	Step 2
Inputs	Step 1
Strategies and Activities	Steps 3-5; Step 5*
Outputs	Steps 3-5
Short-term Outcomes	Step 2, Revise in Steps 3-5,
Intermediate Outcomes	Step 2, Revise in Steps 3-5
Impact	Step 2, Revise in Steps 3-5
Contextual and Influential Factors	Step 1

Remember: SVPP committees will start writing their universal and selected strategy –specific logic models in GTO IPV/SV Step 3 and complete them in GTO IPV/SV Step 6.

Prevention Plan Narrative

As logic model(s) conveys a more visual depiction of the efforts a complementary narrative may provide additional illustration. A Prevention Plan narrative should also tie the goal, inputs, activities, outputs and outcomes together in a logical fashion. Hence, a good narrative does the

same thing as the logic model, but it may add clarity, especially when it conveys the SVPP committee's process of understanding the problem and how certain strategies are believed to be successful or effective at addressing the problem.

The narrative should also include a brief and general timeline description to elaborate on each of the logic model elements. The timeline should clearly illustrate the vision of the chosen strategy and a broad direction of where the SVPP committee is going.

Resources

CDC strongly recommends the below resources to assist grantees in planning, program and/or project efforts. Resources are outlined in three areas:

- Planning;
- Informational; and,
- Training

Planning Resources

CDCYNERGY VIOLENCE PREVENTION EDITION, Your Guide to Effective Health Communication	An interactive tool that is designed to help violence prevention program planners conceptualize, plan, and develop health communication programs. This edition of CDCYNERGY is ideal for those interested in developing prevention programs on the issues of child abuse, intimate partner violence, sexual violence, and youth violence. The six phases will help plan a well-designed health communication plan tailored to the specific needs of the selected violence issue and audience. Contact your Project Officer to request a copy of CDCYNERGY VIOLENCE PREVENTION EDITION.
The Community Tool Box	An internet based "one-stop shopping" service to assist in the promotion of community health and development. The site provides a variety of program planning, implementation and evaluation practice guidelines as well as organizational practices. The Community Tool Box can be accessed on the internet at http://ctb.ku.edu/
Draft Framework for Enhancing Activities for Primary Prevention of Sexual Violence	This draft document provided in the June 2007 National RPE Grantee Meeting Binder in Atlanta, Georgia provides additional information on suggested components for enhancing legislatively approved activities as well as the coalition building, community mobilization, policy and norms change strategies. This document is located in (**Appendix C**).

Draft Rape Prevention and Education (RPE) Practice Guidelines

Practice guidelines for RPE Awardees to support the implementation and evaluation of comprehensive, primary prevention programs and policies. Draft practice guidelines are under development for:

- Sexual Violence Prevention with Children, Youth and Communities
- Training Professionals for Sexual Violence Prevention
- Coalition Building for Sexual Violence Prevention
- Mobilizing Communities for Sexual Violence Prevention
- Developing and Supporting Public and Organizational Polices for Sexual Violence Prevention

RPE Practice Guidelines for Training Professionals for Sexual Violence Prevention will be available for use by Spring/Summer 2008.

Getting to Outcomes (GTO) 2004

A "how-to" workbook that can be used by an organization or coalition to help plan, implement and evaluate its programs and strategies. Includes ten accountability questions that address needs and resource assessment, goals, target populations, desired outcomes (objectives), science and best practices, logic models, fit of programs with existing programs, planning, implementation with fidelity, process evaluation, outcome evaluation, continuous quality improvement, and sustainability.

GTO is designed to be comprehensive and to help the program, strategy, or partnership succeed in reaching its goals. GTO can be accessed at www.rand.org/pubs/technical_reports/TR101/TR101.pdf.

Getting To Outcomes for Primary Prevention of Intimate Partner Violence and Sexual Violence Prevention (GTO IPV/SV)

A 10 step comprehensive needs and resources assessment, planning, implementation and evaluation process for states and communities that promotes improvement and sustaining prevention strategies that show promise to prevent IPV and SV from initially occurring. Please contact your Project Officer for additional information.

GTO IPV/SV Steps 1 and 2 have been distributed via the RPE listserv and at the June 2007 RPE Grantee Meeting in Atlanta.

GTO IPV/SV Steps 3-6 will be available starting in 2008:

- GTO IPV/SV Step 3 – available March 2008
- GTO IPV/SV Step 4* – available March 2008

- GTO IPV/SV Step 5* – important terms and content available March 2008

- GTO IPV/SV Step 6* – available March 2008

*Information on the GTO Steps provided in the guidance document is adapted from the content developed by the GTO Development Team for the GTO IPV/SV Manual. The information provided are the major concepts needed to implement the planning process using the GTO framework. The GTO Steps will be updated and revised as the completed steps become available.

RPE Theory and Activities Models

Creating Safer Communities: RPE Model of Community Change Theory Model; and, Creating Safer Communities: RPE Model of Community Change Activities Models (**Appendix D**) should be used in the planning process.

For information on how to use the above logic models in the planning process, refer to the RPE Theory and Activities Models section of the guidance document.

Sexual Violence Prevention: Beginning the Dialogue

Document produced by CDC to provide guidance to the RPE awardees regarding primary prevention and sexual violence prevention programming. The document can be accessed at http://www.cdc.gov/ncipc/dvp/SVPrevention.htm

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Informational Resources

Suggested resources that can be used to assist grantees as they develop and implement prevention strategies throughout the entire 5 year project period.

National Sexual Violence Resource Center (NSVRC)

NSVRC is a comprehensive collection and distribution center for information, research and emerging policy on sexual violence intervention and prevention.

The NSVRC provides an extensive on-line library and customized technical assistance, as well as, coordinates National Sexual Assault Awareness Month initiatives. NSVRC can be accessed at www.nsvrc.org

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National Youth Violence Prevention Resource Center (NYVPRC)

NYVPRC provides current information developed by Federal agencies or with Federal support pertaining to youth violence. The Resource Center offers the latest tools to facilitate discussion with children, to resolve conflicts nonviolently, to stop bullying, to prevent teen suicide, and to end violence committed by and against young people.

Resources include fact sheets, best practices documents, funding and conference announcements, statistics, research bulletins, surveillance reports, and profiles of promising programs. NYVPRC can be accessed at www.safeyouth.org, and call center, 1-866-SAFEYOUTH (723-3968).

Prevention Institute Website

Prevention Institute is a non-profit national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur.

The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. Prevention Institute can be accessed at www.preventioninstitute.org

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Violence Against Women Network (VAWnet)

A National Online Resource Center on Violence Against Women housed within the National Resource Center on Domestic Violence (NRCDV). VAWnet is an easily accessible and comprehensive collection of full-text, searchable electronic resources on domestic violence, sexual violence and related issues.

VAWnet's primary goal is to support local, state and national violence against women prevention and intervention strategies that are safe, effective, and address the self-identified issues of consequence to victims and survivors. VAWnet can be accessed on the internet at www.vawnet.org

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Training Resources

Prevention Connection

Prevention Connection: The Violence Against Women Prevention Partnership is a national project of the California Coalition Against Sexual Assault (CALCASA) to conduct web conferences, moderate a ListServ and lead on-line discussions to advance primary prevention of violence against women. Prevention Connection can be accessed at www.calcasa.org/159.0.html

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CDC Goals and Lifestages

Background

In June 2003, CDC embarked upon a reorganization to meet the challenges of public health in the 21st century. CDC has aligned its priorities and investment under two overarching health protection goals:

1. Healthy People in Every Stage of Life (Health Protection)
2. People Prepared for Emerging Health Threats (Preparedness)

RPE grantees should be aware and inform their SVPP committees that the proposed strategies and/or programs should align with CDC Health Protection Goals, Lifestages and the proposed National PART Objective; see below for list of goals.

Healthy People in Every Stage of Life Goal

All people, and especially those at greater risk of health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life.

- "Start Strong": Increase the number of infants and toddlers that have a strong start for healthy and safe lives. (Infants and Toddlers, ages 0-3 years).
- "Grow Safe and Strong": Increase the number of children who grow up healthy, safe, and ready to learn. (Children, ages 4-11 years).
- "Achieve Healthy Independence": Increase the number of adolescents who are prepared to be healthy, safe, independent, and productive members of society. (Adolescents, ages 12-19 years).
- "Live a Healthy, Productive, and Satisfying Life": Increase the number of adults who are healthy and able to participate fully in life activities and enter their later years with optimum health. (Adults, ages 20-64 years).
- "Live Better, Longer": Increase the number of older adults who live longer, high quality, productive, and independent lives. (Older Adults, ages 65 and over).

Healthy People in Healthy Places Goal

The places where people, live, work, learn, and play will protect and promote their health and safety, especially those at greater risk of health disparities.

- "Healthy Communities": Increase the number of communities that protect, and promote health and safety and prevent illness and injury

in all their members.

- "Healthy Homes": Protect and promote health through safe and healthy home environments.
- "Healthy Schools": Increase the number of schools that protect and promote the development, health, and safety of all students and staff.
- "Healthy Workplaces": Promote and protect the health and safety of people who work by preventing workplace-related fatalities, illnesses, injuries, and personal health risks.
- "Healthy Healthcare Settings": Increase the number of healthcare settings that provide safe, effective, and satisfying patient care.
- "Healthy Institutions": Increase the number of institutions that provide safe, healthy, and equitable environments for their residents, clients or inmates.
- "Healthy Travel and Recreation": Ensure that environments enhance health and prevent illness and injury during travel and recreation.

Which Goals to Align with Strategies and/or Programs

Ideally, RPE funded strategies and/or programs should align with the CDC's overarching Health Protection goals related to children, adolescents and adults life stages as well as healthy communities, homes, schools and workplaces to promote community change.

National Program Assessment Rating Tool (PART) Objective

What is PART?

The Government Performance and Results Act (GPRA) of 1993 is a law that requires federal agencies to identify both long term and annual goals, collect performance data, and justify budget requests based on these data.

In response to GPRA, the Program Assessment Rating Tool (PART) was developed to assess and improve federal program performance and effectiveness.

PART provides a framework for targeting and designing program improvements by linking program actions to intended outcomes and identifying program strengths and weaknesses to inform funding and management decisions aimed at making the program more effective. Additional information about PART can be accessed at http://www.whitehouse.gov/omb/part/index.html

What is the PART Measure?

The PART measures approved by the Office of Management and Budget (OMB) for the RPE program are:

- Annual Performance Measure – Reduced victimization of youth enrolled in grades 9-12 as measured by reduction in the lifetime prevalence of unwanted sexual intercourse (based on YRBS data).[88]

- Long-term Performance Measure – Impact self-reported victimization of youth enrolled in grades 9-12 as measured by reduction in the lifetime prevalence of unwanted sexual intercourse (based on YRBS data).[89]

Why Align?

The alignment of RPE programs and/or strategies to appropriate CDC Goals for Healthy People in Every Stage of Life, Healthy People in Healthy Places, and the proposed National PART Objective will provide Congress and other stakeholders' valuable information on the progress and impact on attaining the goals and the PART Objective. Thus, it is important for states to have population based data sources. These data sources including surveillance information could be used to measure program impact as well as the progress in attaining CDC's Goals and the proposed PART Objective.

[88] 7.7% of youth responding to the YRBS FY2001 was established a baseline. The goal for FY2009 is 6.7% of youth responding to the YRBS

[89] 7.7% of youth responding to the YRBS FY2001 was established as baseline.

Measures of Effectiveness

Why is it Required?

Grantees are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement.

Measures of effectiveness must relate to the Revised Year 2 Benchmarks for Success and Recommended Timelines; document date is February, 8, 2008. Measures must be objective and quantitative and must measure the intended outcome.

Below are recommended evaluation methods that could be used to measure the effectiveness of Year 2 benchmarks:

- process evaluation – assessing what activities were implemented, the quality of the implementation, and the strengths and weaknesses of the implementation. Process evaluation is used to: 1) produce useful feedback for program refinement: 2) determine which activities were more successfully implemented than others; 3) document successful processes for future replication; 4) demonstrate program activities before demonstrating outcomes; and 5) help interpret outcome evaluation results.

- process indicators – indicators that suggest the intended process or plan is "on track." For example, a process indicator that demonstrates success in developing a collaborative effort may be the establishment of interagency agreements.

What is Expected in the Comprehensive Primary Prevention Plan?

If following GTO IPV/SV, Step 6 begins the development of an evaluation plan.

The development of the evaluation plan (GTO Steps 7-8) should identify specific short term and intermediate benchmarks that would demonstrate the progress and success of the sexual violence primary prevention comprehensive planning, plan development, and implementation processes. These steps should be completed by Year 3 or 4 of the cooperative agreement.

Future Measures of Effectiveness

Ultimately, through the development of the Creating Safer Communities: **RPE Model of Community Change Theory Model and the Creating Safer Communities: RPE Model of Community Change Activities Models (Appendix D)**, meaningful short term and intermediate outcome indicators and measures will be identified by CDC and adopted by the grantees through

the RPE Indicators Project.

Realistic outcome indicators and measures that document a change in individual and community attitude, behavior, and norms towards the prevention of sexual violence perpetration could assist communities in highlighting the effectiveness of their program and/or strategies.

Federal Involvement under Cooperative Agreements

Cooperative Agreement

The RPE Program Announcement CE07-701 has changed from a grant to a cooperative agreement for the next 5 year project period.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring; these activities are:

1. Assist grantees in the translation and application of principles, processes, and practices for primary prevention-focused strategies.

2. Assist awardees in the use of tools and resources related to program planning, implementation and evaluation. Refer to the Program Announcement Guidance Document for specific information related to tools and resources.

3. Convene monthly technical assistance calls to assist awardees in the implementation of proposed activities and strategies including the:

   a. alignment of proposed strategies and/or programs to CDC Goals for Healthy People in Every Stage of Life, Healthy People in Healthy Places, and the proposed National PART Objective;

   b. development of measures that demonstrate performance; and

   c. estimation of health impact to be achieved by program

4. Convene meetings at least annually, for information sharing and trainings related to comprehensive primary prevention planning, implementation and evaluation.

5. Arrange site visits with CDC awardees to assess progress and offer technical assistance related to the cooperative agreement implementation.

6. Coordinate information sharing among relevant CDC awardees and partners via multiple settings such as in- person meetings, conference calls, web seminars, list serves, etc.

7. Disseminate lessons learned to local, state, national, and appropriate international partners via multiple mechanisms such as trainings, conferences, meetings, web casts, and reports.

Training and Technical Assistance Plan	A part of the cooperative agreement process, additional technical assistance may be offered to the awardees by CDC and/or CDC contractors. CDC is in the process of developing a Training and Technical Assistance (TA) Plan to aid and support grantees in the implementation of the cooperative agreement CE07-701.

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